Prepared for
Government of Puerto Rico
Department of Health
Medicaid Program

Technical Response - Redacted

External Quality Review Organization Selection

RFP# 2021-PRMP-RFP-002

February 4, 2022

Submitted by

IPRO
Better healthcare, realized.

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

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Better healthcare, realized.

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Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

ISO 9001:2015 CERTIFIED

January 24, 2022

Elizabeth Otero Martinez
PRMP Central Office
World Plaza Building 12th floor
268 Muñoz Rivera Avenue
San Juan, PR 00918

Re: Request for Proposals for External Quality Review Organization Selection (2021-PRMP-RFP-002)

Dear Ms. Otero:

On behalf of IPRO, I am pleased to submit our proposal to serve as Puerto Rico's External Quality Review Organization.

Our assigned team is supported by IPRO's approximately 400 clinical, quality improvement, and support staff with the specific skills and insights to support the Puerto Rico scope of work. IPRO's management and reporting practices are certified and maintained in compliance with ISO 9001:2015 standards, assuring our customers the highest levels of quality management.

IPRO's primary contact for this procurement is Virginia Hill, Vice President, Managed Care. Ms. Hill can be reached at (516) 209-5518 or ghill@ipro.org. Should you have any questions, please contact Ms. Hill or me at (516) 209-5563 or at cbradley@ipro.org. I am authorized to negotiate and execute any contract on IPRO's behalf that may result from this RFP. Per RFP requirements, IPRO's offer is valid for 150 days after the date of submittal.

Sincerely,

Clare B Bradley

Clare B. Bradley, MD, MPH
Chief Medical Officer

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A. Mandatory Requirements

A.1. Proposal Delivery

IPRO has delivered its response to the Puerto Rico Medicaid Program (PRMP) by the specified proposal submission date.

A.2. Proposal Packaging

IPRO has packaged its Technical Response and Cost Proposal separately.

A.3. Separate Cost Information

IPRO has not included cost or pricing information in its Technical Response.

A.4. No Restrictions or Qualifications

IPRO's Technical Response does not contain any restrictions of PRMP rights or other qualification.

A.5. No Alternate Responses

IPRO is not submitting alternate responses.

A.6. Single Response

IPRO is not submitting multiple responses in different forms.

A.7. Statement of Certifications and Assurances

IPRO's completed Statement of Certifications and Assurances is provided in Section D.1.

A.8. Statement Regarding Conflict of Interest

IPRO does not have any possible conflict of interest with any employee or official of the Puerto Rico Department of Health, the Puerto Rico Health Insurance Administration (ASES), or any other Puerto Rico government agency.

A.9. Attestation Regarding Excluded Employees

IPRO does attest, certify, warrant and help assure that it will not knowingly employ, in the performance of the contract, employees who have been excluded from participation in the Medicare, Medicaid, and/or Children's Health Insurance Program (CHIP) Programs pursuant to Sections 1128 of the Social Security Act.

A.10. Disclosure of Lobbying Activities

IPRO has not hired any corporation to perform lobbying activities and no partner or employees of IPRO are engaged in this type of activity. A written certification to this effect is provided in Section D.2.

A.11. Audited Financial Statements

IPRO's audited financial statements are provided in Section D.3.

A.12. Sworn Statement on Fraud, Misappropriation, and Debarment

IPRO's completed Sworn Statement on Fraud, Misappropriation, and Debarment is provided in Section D.4.

A.13. Pending Litigation

There is no material, pending litigation against IPRO.

B. General Qualification and Experience

B.1. Contact Information

Name	Clare B. Bradley, MD, MPH
Email Address	cbradley@ipro.org
Mailing Address	1979 Marcus Avenue, Lake Success, NY 11042
Telephone Number	(516) 209-5563
Facsimile Number	(516) 328-2310

B.2. Form of Business

IPRO is a 501(c)(3) not-for-profit corporation located in Lake Success, NY.

B.3. Years in Business

IPRO, a New York-based not-for-profit corporation, was established on July 27, 1983 and began operations in 1984 as a local peer review organization. Since then, IPRO has evolved and grown to provide healthcare assessment and quality improvement services. We conduct our healthcare oversight activities under contract to federal, state, and local government, focusing primarily on improving outcomes and healthcare value for Medicaid and Medicare beneficiaries.

B.4. Years Providing Goods and Services Required in RFP

IPRO has served as an External Quality Review Organization (EQRO) continually for more than 30 years, starting in 1989, in New York State, which has the second largest Medicaid managed care population in the country. This experience predates the issuance of the federal external quality review (EQR) protocols by 15 years, making IPRO the most experienced and qualified EQRO in the nation.

B.5. Employees, Client Base, and Location of Offices

Employees. IPRO employs a multidisciplinary staff of approximately 400 with the diverse skills needed to support EQR activities and will provide staff with demonstrated experience and knowledge of all tasks included in the Puerto Rico EQRO scope of work. Our proposed staff for the Puerto Rico EQRO contract includes a Puerto-Rico based, bilingual Communications Liaison and Compliance Reviewer.

IPRO has extensive staffing resources devoted to supporting Medicaid and Medicare programs under contract to state and federal government. We hire academically and empirically qualified healthcare professional staff to carry out EQR contract activities, including physicians, registered nurses (RNs), epidemiologists, biostatisticians, psychometricians, medical record reviewers and coders, healthcare data analysts and programmers, surveyors, health information specialists, Healthcare Effectiveness Data and Information Set (HEDIS) auditors, and individuals with

special expertise in areas such as healthcare quality improvement, behavioral health, pharmacy, data and analytics, long-term care, public policy, and many others. Our staff possess diverse and in-depth knowledge of Medicaid beneficiaries, policies, data systems and processes; NCQA standards, tools, and data; and managed care delivery systems, organizations, and financing; as well as competency in research design and methodology, statistical analysis, and meaningful technical report writing.

IPRO engages and manages subcontractors to augment or supplement in-house skills as appropriate. A senior-level manager (Contract Manager) who is experienced in managing subcontractor staff ensures the quality of their work products.

Client Base. IPRO serves as prime EQRO in 11 states and territories: Alabama (since 2019), Kentucky (since 2005), Louisiana (since 2011), Minnesota (since 2013), New Jersey (since 2011), New Mexico (since 2018), New York (since 1989), Ohio (since 2019), Pennsylvania (since 1999), Puerto Rico (since 2011), and Rhode Island (since 2003). We also conduct EQR activities under subcontract in North Carolina (since 2016) and served as EQRO in Nebraska from 2007 to 2021.

In addition to our EQR work, IPRO manages large-scale Medicaid quality improvement, utilization management, and provider compliance oversight contracts with the New York State Department of Health. IPRO is also URAC-accredited to conduct independent review of consumer-appealed health plan decisions and does so under our 18 state Independent Review Organization contracts, for 16 state-government agencies.

At the federal level, IPRO is a Centers for Medicare and Medicaid Services (CMS) Hospital Quality Improvement Contractor, working with 270 hospitals in 12 states, (DE, KY, MA, MD, ME, MN, MI, NJ, NY, PA, OH, and WI). We hold four CMS End-Stage Renal Disease (ESRD) Network contracts, spanning 13 states (CT, GA, IN, KY, ME, MA, NC, NH, OH, RI, SC, and VT). We also serve as a prime CMS Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for 12 states/territories (CT, DE, DC, ME, MD, MA, NH, NJ, NY, OH, RI, and VT) and as a subcontractor in seven additional states (AL, FL, GA, KY, LA, NC, TN). We have held a QIO contract with CMS for more than three decades, working with providers across the healthcare continuum to measure and improve the quality and value of care for Medicare beneficiaries. We are also certified as a CMS QIO-Like Entity.

Offices. IPRO is headquartered in Lake Success, NY and maintains offices in Albany, NY; Hamilton, NJ; Morrisville, NC; Hamden, CT; and Beachwood, OH.

B.6. Bankruptcy and Insolvency

IPRO has not filed any bankruptcy or insolvency proceeding in the last 10 years.

B.7. IPRO's Ability to Deliver Goods and Services

With more than 30 years of experience conducting managed care assessment and improvement activities, currently working with more than 150 managed care entities across the US, IPRO successfully performs all of the activities detailed in the request for proposals (RFP). Our multi-state experience, combined with our in-depth knowledge of the Medicaid program, ensures the high quality of services IPRO will continue to bring to Puerto Rico's Medicaid program.

IPRO has served as an EQRO continually for more than 30 years. Our experience predates the issuance of the federal EQR protocols by 15 years, making us the most experienced and qualified EQRO in the nation. We are currently the EQRO for 11 states and territories (and serve as a subcontractor in one additional state).

B.8. Project Team, Members, and Organizational Structure

IPRO has extensive experience in planning and managing healthcare projects that range from simple to complex and from local to national in scope. To execute the Puerto Rico EQRO contract, we will continue to use the most effective practices and controls to ensure the timely and successful completion of all tasks. IPRO's Contract Manager will direct and monitor all contract activities, ensuring a high level of supervision and quality control. All Puerto Rico EQRO team members will understand their roles and responsibilities, and IPRO and PRMP expectations.

For each EQR activity, we have assigned a Task Lead who is an expert in the activity and who will lead project team members with the required skills in completing the task. Staff will also contribute their skills to multiple tasks, as needed. The Contract Manager will coordinate all project activities and will serve as the primary liaison to PRMP.

Through continual interaction with each other and the Contract Manager, IPRO's Puerto Rico EQRO team members will continue to develop a deeper understanding of PRMP's needs and ways of working, leading to effective and efficient coordination of activities and helping each team member understand how their individual assignments fit into the overall success of the project.

Exhibit 1 presents an organizational chart with administrative and operational components, team structure, and positions, and shows lines of responsibility and authority.

B.9. Key Personnel Roster and Resumes

Our proposed key personnel are provided in Exhibit 2.

Resumes for our proposed key staff are provided following this page.

B.10. Subcontractors

IPRO is not proposing to use subcontractors for this contract.

B.11. References

Completed reference questionnaires for the following clients are provided in sealed envelopes with this proposal.

B.12. IPRO's Commitment to Diversity

IPRO has a longstanding commitment to working with small businesses, in particular, small disadvantaged businesses, including minority/women-owned business enterprises (MWBEs), veteran-owned and service-disabled veteran-owned businesses, and businesses in HUBZone areas. We have implemented a formalized plan to identify and establish partnerships with small businesses that provide services supporting our business efforts across the country.

We will also work with Puerto Rico to identify suitable Puerto Rico businesses to support our work on this contract. For instance, we could engage a Puerto Rico-based printing vendor to

support provider network validation work and nurses located in Puerto Rico to conduct compliance reviews and PIP validation.

C. Technical Qualifications

C.1. Staff Experience and Knowledge of Medicaid

IPRO's diverse staff includes professionals with the experience, knowledge, and skills needed to successfully perform EQR for Puerto Rico. A summary of expertise for our proposed project staff, including their demonstrated experience and knowledge of Medicaid beneficiaries, policies, data systems, and processes; managed care delivery systems, organizations, and financing; quality assessment and improvement methods; and research design, methodology, and statistical analysis is provided in Exhibit 3.

Additional details on our staff qualifications are provided in our staffing plan in Section C.6 and the key personnel resumes in Section B.9.

C.2. Staff Experience and Knowledge of Managed Care

A summary of our proposed staff's demonstrated experience and knowledge of managed care delivery systems, organization, and financing is provided in Section C.2. Additional details on our staff qualifications are provided in our staffing plan in Section C.6 and the key personnel resumes in Section B.9.

C.3. Staff Experience and Knowledge of Quality Assessment and Improvement Methods

A summary of our proposed staff's demonstrated experience and knowledge of quality assessment and improvement methods is provided in Section C.2. Additional details on our staff qualifications are provided in our staffing plan in Section C.6 and the key personnel resumes in Section B.9.

C.4. Staff Experience and Knowledge of Research Design and Methodology

A summary of our proposed staff's demonstrated experience and knowledge of research design and methodology, including statistical analysis, is provided in Section C.2. Additional details on our staff qualifications are provided in our staffing plan in Section C.6 and the key personnel resumes in Section B.9.

C.5. Sufficient Physical, Technological, and Financial Resources to Conduct EQR

IPRO maintains six offices in five states. Puerto Rico EQRO contract activities will continue to be managed from our headquarters in Lake Success, NY. Our office houses over 77,000 square feet of secure, modern office space, fully equipped with state-of-the-art systems for technology and security, including local and wide area networking, voicemail, video conference services, fax, high-volume printing, data communications, copying, document imaging, computer networking, PCs, and all other systems required to conduct business. The office houses a secure computer room, offices, reception, central records, printing, mailroom, conference rooms, and all other facilities to accommodate the needs of professional and support staff. A full complement of support services is provided through our Office Operations, Finance, Human Resources, Communications Solutions, Corporate Development, Digital Health, and Information Systems Departments.

IPRO's financial resources are more than sufficient to successfully conduct the Puerto Rico EQRO scope of work. IPRO maintains a longstanding, stable client base that includes federal, state, and local government agencies and private companies, several of whom have been customers since IPRO was founded. IPRO has never had a contract terminated for non-performance or for any other reason.

C.6. Staffing Summary Plan and Clinical and Nonclinical Skills to Carry Out EQR

C.6.1. Staffing Summary Plan

With our extensive background and contract work in Medicaid and Medicare quality improvement and utilization management, and ~400 healthcare staff to draw from, IPRO possesses all of the resources and skills required to complete the proposed EQR scope of work to PRMP's satisfaction. IPRO will be solely accountable for the work, allowing us to provide the services at a reasonable cost and offering a single point of contact to PRMP.

IPRO has a sufficient number of individuals assigned to the team to ensure the availability of all needed skills and timely completion of all deliverables for the upcoming scope of work.

A Task Lead has been assigned for each EQR activity. Staff will also contribute their skills to multiple tasks, as needed. The Puerto Rico EQRO organizational chart in Section B.8 provides additional detail on staff assigned to each task. Full details of our staff roles and responsibilities are provided in Exhibit 4. Resumes for our key (🗝) personnel are provided in Section B.9.

C.6.2. Clinical and Nonclinical Skills to Carry Out EQR

C.7. Understanding of PRMP's Requirements and Project Schedule

C.7.1. Understanding of Issues Important to Puerto Rico

The Commonwealth of Puerto Rico prioritizes healthcare issues based on how they impact their healthcare objectives in terms of health outcomes, access to quality care, social determinants of health (SDOH), and cost. The goals of PRMP and ASES, as promulgated in the Puerto Rico Quality Management Strategy, aim to improve access to primary and preventive care services, physical and behavioral health integration, and member experience and satisfaction (Gobierno De Puerto Rico, 2019).[1] Puerto Rico is notable for its strengths, from the generosity and resiliency of its society to the health promotion outreach of the committees and coalitions of the Regional Boards (HRSA, 2021).[2] Further, Puerto Rico's workforce has demonstrated a commitment to disaster response, namely, the Zika epidemic, Hurricane Maria, earthquakes, and the COVID-19 pandemic (HRSA, 2021).[3] Yet, Puerto Rico residents face significant health challenges compared to other states.

Prior to Hurricane Maria, key health status indicators for Puerto Rico compared unfavorably with those of the rest of the United States. More than one third of adults in Puerto Rico reported fair or poor general health compared to 18% in the 50 states and Washington, DC (KFF, 2017).[4] Healthcare statistics reveal disparities in chronic illness prevalence. The national rate for self-reported diabetes prevalence is 11%, compared to 15% for Puerto Rico, and more than 10 percent of Puerto Ricans report having a heart attack or heart disease, compared to only 7% of the 50 states and Washington, DC (KFF, 2017).[5] Further, Sacco et al. (2017)[6] reported racial-ethnic and geographic disparities in acute stroke performance measures. Disparities in infectious disease prevalence are also notable, from the 2015 HIV diagnosis rate per 100,000 people of 17.1

[1] Gobierno De Puerto Rico. Puerto Rico Quality Management Strategy. 2019. https://www.asespr.org/wp-content/uploads/2019/06/PR-Medicaid-Quality-Management-Strategy-2019.pdf [Accessed 24 January 2022]
[2] U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA). III.B. Overview of the State- Puerto Rico – 2021. Puerto Rico - 2021 - III.B. Overview of the State (hrsa.gov) [Accessed 24 January 2022]
[3] Ibid.
[4] Kaiser Family Foundation (KFF). Puerto Rico: Fast Facts. Fact Sheet. October 2017.
[5] Ibid.
[6] Sacco RL, Gardener H, Wang K, Dong C, Ciliberti-Vargas M, Gutierrez CM, Asdaghi N, et al. Racial-ethnic disparities in acute stroke care in the Florida-Puerto Rico Collaboration to reduce stroke disparities study. J Am Heart Assoc. 2017;6:e004073. EOI: 10.1161/JAHA.116.004073.

in Puerto Rico versus 14.7 in the 50 states and Washington, DC, to the 2016 Zika virus case count of 34,963 in Puerto Rico to 224 cases in the 50 states and Washington, DC (KFF, 2017).[7]

One year after Hurricane Maria, one third of adults reported problems accessing medical care for at least one of the following: emergency care (10%), prescription medication (15%), the same doctor (15%), needed medical care (16%), and appointments with specialists (20%; DiJulio et al., 2018).[8] Subsequently, chronic condition prevalence has increased for hypertension, elevated cholesterol and triglycerides, arthritis, eye disease, fatty liver disease, and osteoporosis (Mattei et al., 2022).[9] The following unhealthy behaviors showed a corresponding increase: abdominal obesity, sedentarism, and binge drinking (Mattei et al., 2022).[10] More recently, as of January 23, 2022, the seven-day COVID-19 death rate for Puerto Rico is five deaths per 100,000 population, compared to 4.2/100,00 for the United States overall (CDC, 2022).[11] Quiñones et al. (2021)[12] highlight how the COVID-19 pandemic has exacerbated the use of opioids in Puerto Rico, with dramatic increases in fentanyl-laced heroin and cocaine overdoses.

Pediatric health issues in Puerto Rico pose challenges to the most vulnerable. Although Puerto Rico experienced a decline in preterm birth rate from 2010 to 2020, the 11.6% preterm birth rate earned a grade of "F" in the 2021 March of Dimes Report Card, compared to the overall US rate of 10.1%. The American Psychological Association (2019)[13] reports that 23% of Puerto Rican youth experienced anxiety post Hurricane Maria and, although exposure to natural disasters is an established risk factor for pediatric post-traumatic stress disorder, children in Puerto Rico are underserved in terms of receipt of evidence-based interventions. Of note, the proportion of students in Puerto Rico who reported suicidal ideation increased from 12.3% in 2015 to 17.1% in 2017 (Baerga-Santini, 2020).[14] Social determinants of health are a related driver of mental health issues for children in Puerto Rico, as half of families with children earning $15,000 or less

[7] Kaiser Family Foundation. Puerto Rico: Fast Facts. Fact Sheet. October 2017.
[8] DiJulio B, Muñana C, Brodie M, Kaiser Family Foundation. Views and Experiences of Puerto Ricans One Year After Hurricane Maria. The Washington Post/Kaiser Family Foundation Survey of Puerto Rico Residents, 2018.
[9] Mattei J, Tamez M, O'Neill J, Haneuse S, Mendoza S, Orozco J, et al. Chronic diseases and associated risk factors among adults in Puerto Rico after Hurricane Maria. JAMA Network Open. 2022; 5(1):e2139986. Doi: 10.1001/jamanetworkopen.2021.39986.
[10] Ibid.
[11] Centers for Disease Control and Prevention. COVID Data Tracker. United States COVID-19 Cases, Deaths, and Laboratory Testing (NAATs) by State, Territory, and Jurisdiction. January 23, 2022. https://covid.cdc.gov/covid-data-tracker/#cases_deathsper100klast7days [Accessed 24 January 2022].
[12] Quiñones DS, Melin K, Roman L, Rodriguez F, Alvarado J, Rodríguez-Díaz C. Treating opioid use disorder in Puerto Rico during the COVID-19 pandemic: Providers' leadership efforts in unprecedented times. J Addict Med, 2021; 15: 276-279.
[13] American Psychological Association. State of mental health services for children in Puerto Rico. https://www.apa.org/pi/families/resources/newsletter/2019/mental-health-puerto-rico-children. [Accessed 24 January 2022].
[14] Baerga-Santini K. A look at the mental health of children and adolescents in Puerto Rico. https://ncdp.columbia.edu/custom-content/uploads/2020/06/Session-6_Mental-Health_Baerga_EN.pdf [Accessed 24 January 2022].

reported food, employment, and economic insecurity, with 31% of families with children experiencing poverty (APA, 2021).[15]

Through our numerous contracts, which include EQRO, QIO, and other Medicaid and Medicare contracts, IPRO is already working with our clients to address issues designated as priority areas by Puerto Rico and is fully prepared to partner with PRMP and ASES to achieve Puerto Rico's healthcare improvement goals.

As a not-for-profit organization, IPRO is committed to partnering with government and private organizations to benefit the greater good of society, focusing our resources on activities that support our underlying principles. Our core business activities promote increasing access to higher quality healthcare services delivered more efficiently and cost-effectively. We work across multiple healthcare platforms to help providers achieve targeted improvements in care; we support performance transparency to help consumers make educated decisions about their healthcare; and we work with governments to maximize the value of Medicaid dollars through data integrity activities, to name a few examples.

Our strategic direction is set by our Board of Directors, which consists of physicians, patient representatives, and healthcare community stakeholders, all with diverse perspectives but with the common desire to achieve better healthcare outcomes in a financially rational manner.

Our Managed Care Department was established with the specific goal of helping government and Medicaid contracted health plans meet federal and state performance standards for quality of and access to healthcare, and to implement sustainable improvements in care. Our 50+ experienced and dedicated managed care experts possess all the skills and experience needed to assist Puerto Rico in meeting its goals for its Medicaid and Platino plans.

C.7.2. Project Schedule

Our project design will be guided by a detailed work plan that groups tasks and deliverables by major activity. This work plan will serve as the guide for coordinating and conducting the work and for reporting accomplishments against the plan. Regular internal team status meetings will be convened to report on the status of each activity, anticipate upcoming tasks, and identify challenges. We will develop and finalize a comprehensive detailed annual work plan based on discussions with PRMP during kickoff. The annual work plan will be maintained by IPRO's Contract Manager, with ongoing status updates and changes that may occur. Each contract year, the plan will be revised in discussions with PRMP to reflect changes in Puerto Rico priorities, program expansion, regulations, and any other factor that is likely to affect delivery of EQR

[15] American Psychological Association (APA). State of mental health services for children in Puerto Rico. https://www.apa.org/pi/families/resources/newsletter/2019/mental-health-puerto-rico-children. [Accessed 24 January 2022].

services. The work plan will incorporate a project schedule to ensure timely delivery of all tasks. A draft project schedule for Year 1 is provided in Exhibit 5.

C.8. MCO Annual Quality Survey

IPRO will conduct comprehensive compliance reviews to assess the Medicaid and Platino plans' compliance with federal and state regulations regarding access to care, structure and operations, and quality measurement and improvement. Our methodology is in full compliance with the CMS protocol for conducting compliance review.

The compliance review will determine plan compliance with PRMP contract requirements and with state and federal regulations in accordance with the requirements of 42 CFR §438.

The compliance review activity will cover all applicable standards as required by 42 CFR 438, Subparts D and E as follows:

- Availability of services (438.206) (Access)
- Assurances of adequate capacity and services (438.207) (Access)
- Coordination and continuity of care (438.208) (Access)
- Coverage and authorization of services (438.210) (Access)
- Provider selection (438.214) (Structure and Operations)
- Confidentiality (438.224) (Structure and Operations)
- Grievance and appeal systems (438.228) (Structure and Operations)
- Subcontractual relationships and delegation (438.230) (Structure and Operations)
- Practice guidelines (438.236) (Measurement and Improvement)
- Health information systems (438.242) (Measurement and Improvement)
- Quality assessment and performance improvement program (438.330) (Measurement and Improvement)

Also, certain requirements in Subparts A, B, C and F are incorporated into the compliance review through interaction with Subparts D and E, such as enrollee rights and protection (Structure and Operations and Access), and compliance with Program Integrity requirements will be included as requested by PRMP.

C.8.1. Compliance Review Pre-Onsite Activities

C.8.2. Compliance Review Annual Onsite/Remote Activities

C.8.3. Compliance Review Post-Onsite Activities

C.9. Sample Annual Quality Review and Survey Tool

A sample MCO-specific compliance review for one of our state clients is provided in Section D.6. The review includes an Audit Overview section (executive summary) demonstrating how IPRO designed, developed, and implemented a tool to capture all CMS requirements. This report also includes, as an appendix, the compliance review tool that IPRO developed.

C.10. EPSDT Annual Evaluation Report

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federally mandated health program that provides comprehensive and preventive healthcare services for children and adolescents up to age 21 who are enrolled in Medicaid. EPSDT services are designed to ensure early identification of conditions that can impede children's health and development, and provide for the diagnosis and treatment of physical and mental health conditions, in order to improve health outcomes. The CMS guidelines for state Medicaid programs include informing eligible children and adolescents of available services, as well as providing or arranging for screening and necessary corrective treatment.

A sample report is provided in Section D.8.

C.11. Network Adequacy and Health Benefit Delivery Assessment

IPRO is proficient in all aspects of network adequacy assessment and validation and has 20+ years' experience in this activity. We currently analyze the adequacy of provider managed care networks in Kentucky, Louisiana, New Mexico, New York, New Jersey, Ohio, and Rhode Island. Our process conforms to the CMS protocol, currently in draft form. Of note, IPRO provided insights and expertise on network adequacy to inform the development of the draft protocol.

MCO provider networks must include sufficient numbers of providers and provider types to deliver contracted services to their target populations and to meet Puerto Rico accessibility standards.

C.12. Validation of Provider-Related Information

The purpose of this activity is to validate MCO provider-related information published in the MCOs' provider directories. This validation is performed to ensure MCOs have adequate provider networks and that members are being provided accurate and up-to-date information regarding the providers comprising the network.

C.13. Technical Assistance

C.14. Sample Comparative Analysis on HEDIS, CAHPS, or Similar Data

A sample spreadsheet comparing HEDIS rates across plans as part of a performance measure validation report we produced for Kentucky is provided in Section D.12. Additionally, the Executive Summary from a CAHPS report we developed for another state, which includes narrative, graphical, and tabular comparative analyses, is provided in Section D.13.

C.15. Validation of Performance Improvement Projects

IPRO has extensive experience reviewing PIP proposals and implementing the CMS PIP validation protocol in several states. Our managed care staff validate more than 150 PIPs annually, tailoring our methodology to meet our clients' requirements. We have reviewed project proposals and reports; consulted with plans and states on project development, methodology, and execution; performed continuous oversight; and provided ongoing technical assistance. As an

EQRO, IPRO validates the methodology used to conduct PIPs and measure outcomes in compliance with the most current CMS Validating Performance Improvement Projects protocol.

PIPs promote improvements in quality of care and outcomes for plan enrollees. They can identify healthcare disparities and assist plans in reducing performance gaps in health outcomes and member satisfaction. Successful PIPs address a significant issue, either clinical or nonclinical, in the healthcare system and produce meaningful and sustainable improvements in performance.

The PIP process is iterative and data-driven. It requires appropriate identification of a topic of interest to the client, a clear statement of the study question, analysis of the plan's past performance and barriers to improvement, development of proactive interventions that address those specific barriers, measurement of progress, and continuous evaluation of the effectiveness of the interventions. External review of PIPs ensures that projects are designed and conducted soundly and, if deficiencies are identified, timely modifications are made. It also provides PRMP and other stakeholders with confirmation that the project results are meaningful.

C.15.1. Preparation of Validation Methodology

C.15.2. PIP Submission Form

C.15.3. PIP Validation Methodology

C.15.4. PIP Interim and Final Reports

C.16. Sample Technical Report

IPRO produces MCO-specific and/or statewide aggregated annual technical reports to present our findings relative to the EQR for more than 150 MCOs, customizing report content and format to meet individual state needs and preferences and in compliance with CMS requirements. We submit timely comprehensive reports containing all CMS-required content and state-defined supplementary content, designed to be understood by a broad range of stakeholders.

A sample annual technical report that IPRO produced for Minnesota is provided in Section D.15.

C.17. Validation of MCO Performance Measures

IPRO's strategy for conducting validation of performance measures is based on our successful performance under several EQRO contracts. In describing our strategy, we address the organizational structures in place, our knowledge of the activity, IPRO's data collection methodology, how we ensure timely activity completion, and the reporting associated with the activity.

This task assesses the accuracy and reliability of the performance measures reported by the plans and determines the extent to which the performance measures calculated by the plans follow established measure technical specifications and are in accordance with the specifications in 42 CFR §438. The CMS protocol for validating performance measures includes reviewing the data management processes of the plan, evaluating algorithmic compliance (the translation of captured data into actual statistics) with HEDIS Technical Specifications, and verifying performance measures to confirm that the reported results are based on accurate source information.

C.17.1. IPRO's Performance Measure Validation Processes for HEDIS Performance Measures

IPRO will complete all aspects of performance measure data collection and review. IPRO is NCQA-licensed to conduct HEDIS Compliance Audits, and our performance measure validation activity will be led by a Certified HEDIS Compliance Auditor. Key performance measure validation tasks will include preparing the plans for validation, providing technical assistance, collecting the data, conducting the validation review, and reporting the findings. We will evaluate each plan's information system integrity and capability to report performance measures. The audit will follow the structure of HEDIS compliance audits and will be fully compliant with CMS Protocol 2: Validation of Performance Measures.

C.17.2. Audit Approach

C.17.2.1. Communication and Coordination

C.17.2.2. Audit Process/Methodology

C.18. Sample Collaborative Work Product

C.19. Staff Training and Education

As an experienced and successful EQR contractor, IPRO has in place outstanding personnel who are well-versed in the operational and technical requirements of the activities in the Puerto Rico scope of work and are experienced in their respective roles and duties.

IPRO has proposed professionals who possess all required experience, credentials, skills, expertise, and knowledge needed to conduct EQR and other activities as outlined in the scope of work. Our project team includes individuals who are conducting the same or similar tasks under our current EQR contracts and several who have conducted these tasks previously in Puerto Rico.

C.20. Inter-Rater Reliability and Reporting Accuracy and Completeness

C.20.1. Inter-Rater Reliability

C.20.2. Internal Controls to Ensure Accuracy and Completeness of Reporting

C.21. Population Health and Disease Management Experience, Monitoring, and Feedback

C.22. Mechanisms to Remain Current on State and Federal Requirements

As an EQRO in 11 states and territories, IPRO is consistently up to date on all federal EQRO regulations, specifically 42 CFR Part 438, Subpart E, External Quality Review and all related protocols. As the EQRO for Puerto Rico, we also stay abreast of changes in MCO contracts, public programs, and state or federal managed care regulations specific to Puerto Rico.

C.23. Internal Controls to Safeguard Data and Contingency Plan for Data Systems Failure

C.23.1. Ongoing Internal Controls to Safeguard Access to Data

C.23.1.1. Administrative Safeguards

C.23.1.2. Technical Safeguards

C.23.1.3. Physical Safeguards

C.23.2. Contingency Plan for Data Systems Failure

C.23.2.1. Business Continuity and Contingency Plan (BCCP)

C.24. Meetings With MCOs and Oversight Agencies

Meeting Puerto Rico's goals for the EQR program will require continued partnership between IPRO and PRMP. We will be proactive and generous in collaborating with PRMP, MCOs, and interrelated oversight agencies. IPRO's Contract Manager will confer regularly with PRMP to exchange information and identify appropriate topics for meetings. We use a variety of methods such as webinars, conference calls, onsite/remote presentations, and printed and electronic materials to conduct meetings and provide technical assistance.

D. Appendices

The appendices listed below are provided in the pages that follow:

- Statement of Certifications and Assurances
- Disclosure of Lobbying Activities
- Audited Financial Statements
- Sworn Statement on Fraud, Misappropriation, and Debarment
- Quality/Compliance Review Tool
- Sample Quality/Compliance Review Report
- Sample EPSDT Evaluation Tool
- Sample EPSDT Evaluation Report
- Sample Network Adequacy Review Tool
- Sample Provider Information Validation Survey Tool
- Sample Provider Information Validation Report
- Sample HEDIS Comparative Analysis Spreadsheet
- Sample CAHPS Comparative Analysis Report Chapter
- Sample PIP Report Template
- Sample Annual Technical Report
- Sample Collaborative Work Product

D.1. Statement of Certifications and Assurances

IPRO's Statement of Certifications and Assurances is provided following this page.

Appendix 1: Statement of Certifications and Assurances

The respondent must sign and complete the Statement of Certifications and Assurances below as required and it must be included in the Technical Response (as required by RFP Appendix 2: Technical Response and Evaluation Guide, Section A).

The respondent does, hereby, expressly affirm, declare, confirm, certify, and help assure all of the following:

1. The respondent will comply with all the provisions and requirements of the RFP.
2. The respondent will provide all services as defined in the scope of the RFP Appendix 10: Pro Forma Contract Draft.
3. The respondent, except as otherwise provided in the RFP, accepts and agrees to all terms and conditions set out in the RFP Appendix 10: Pro Forma Contract draft.
4. The respondent acknowledges and agrees that a contract resulting from the RFP shall incorporate, by reference, all proposal responses as a part of the contract.
5. To the knowledge of the undersigned, the information detailed within the response submitted to this RFP is accurate.
6. The response submitted to this RFP was independently prepared, without collusion, under penalty of perjury.
7. No amount shall be paid directly or indirectly to a Puerto Rico employee or official as wages, compensation, or gifts in exchanges for acting as an officer, agent, employee, subcontractor, or consultant to the respondent in connection with this RFP or any resulting contract.
8. Both the Technical Response and the Cost Proposal submitted in response to this RFP shall remain valid for at least 120 days subsequent to the date of the Cost Proposal opening and thereafter in accordance with any contract pursuant to the RFP.

By signing this Statement of Certifications and Assurances, below, the signatory also certifies legal authority to bind the proposing entity to the provisions of this RFP and any contract awarded pursuant to it. If the signatory is not the respondent (if an individual) or the respondent's company President of Chief Executive Officer, this document must attach evidence showing the individual's authority to bind the respondent.

DO NOT SIGN THIS DOCUMENT IF YOU ARE NOT LEGALLY AUTHORIZED TO SIGN FOR THE RESPONDENT

SIGNATURE: _____

PRINTED NAME & TITLE: Theodore O. Will, Chief Executive Officer

DATE: 1/13/22

RESPONDENT LEGAL ENTITY NAME: IPRO

D.2. Disclosure of Lobbying Activities

IPRO's Disclosure of Lobbying Activities is provided following this page.

Appendix 6: Disclosure of Lobbying Activities (Respondent Only)

The respondent shall also disclose if any corporation was hired to perform lobbying activities or notify if any partner or employees of the corporation are engaged in this type of activity.

This disclosure must be delivered via a written certification by the legal representative of the respondent. If there were no lobbying activities, then a negative certification must be sent as part of the process.

Failure to disclose this information **will result in disqualification from the process.**

IPRO has not hired any corporation to perform lobbying activities and no partner or employees of IPRO are engaged in this type of activity.

Signature: Clare B Bradley

Name: Clare B. Bradley, MD, MPH, Chief Medical Officer

Date: 1/13/22

D.3. Audited Financial Statements

IPRO's three years of audited financial statements are provided following this page.

D.4. Sworn Statement on Fraud, Misappropriation, and Debarment

IPRO's Sworn Statement on Fraud, Misappropriation, and Debarment is provided following this page.

Appendix 7: Sworn Statement on Fraud and Misappropriation and Debarment (Respondent Only) As Required by Puerto Rico Law #2 of January 4th, 2018

Sworn Statement

I (full name) Theodore O. Will of legal age (profession) Chief Executive Officer and resident of (city and sta most solemn oath,

1. That my name and other personal circumstances are as previously described.

2. That the Board of Directors has been informed of the content of this sworn statement and that it has authorized me by means of a resolution of the Board of Directors to subscribe this sworn statement.

3. That I am the President of the company (organization name) _____, which is duly organized and or authorized to do business pursuant to the Laws and regulations of the Government of Puerto Rico. Or in the alternative: That I am in the Chief Executive Officer (position) of (entity Name) IPRO and because the President is not available to notarize this document, I have been authorized according to paragraph 2, for signing this sworn statement.

4. That I am legally authorized by the company to sign this sworn statement.

5. That in the best of my knowledge and after diligent investigation, the company, its subsidiary companies, affiliates, and or headquarters, and their respective shareholders, directors, associates, officers, executives, principals and/or employees, and/or business associates, have not been convicted, no probable cause has been found for their arrest, nor they are under investigation in any legislative, judicial or administrative procedure, whether in or out the jurisdiction of Puerto Rico, for reasons of any conduct that may be held to constitute fraud, embezzlement or illegal appropriation of public funds, according to the provisions of Act 2 of January 4, 2018 known as the "Anticorruption code for the New Puerto Rico", or any another legal provision that penalizes crimes against the treasury and the public confidence, and neither have I, the declarant, been investigated, arrested, convicted, declared guilty nor sentenced for the conducts previously mentioned. Or In the alternative: in the case of having knowledge that any of the persons identified in the above-mentioned positions or categories have been on are being investigated, arrested, declared guilty, convicted or sentenced for such conduct and/or criminal offences referred to in the preceding paragraph, a statement regarding this fact shall form part of this sworn declaration. The statement must be included in an additional sheet describing positions, full names, charges, description of the offence or offences for which they have been or are being investigated, convicted, or sentenced, including current processes status.

6. I give faith that I have personal knowledge, as does the company, its subsidiary, companies, affiliates, and or headquarters, and/or their respective shareholders, directors, associates, officers, executives, principals, and or employees, that the crimes referred to in these provisions include, but are not limited to:

a. Aggravated illegal appropriation, in all of its modalities;
b. Extortion;
c. Fraud in constructions;
d. Fraud in the execution of construction work;
e. Fraud in the delivery of things;
f. Undue intervention in the contracting processes of auctions or in the operations of the government;
g. Bribery, in all its modalities;
h. Aggravated bribe;
i. Offering a bribe;
j. Undue influence;
k. Crimes against public funds;
l. Preparation of false documents;
m. Forgery of documents;
n. Possession and transfer of false documents; and
o. Crimes under the laws of the United States and its territories and state jurisdiction of the United States, whose elements are equivalent to those of the crimes aforementioned.

7. That I have been advised by my legal advisors and company's counsels on the obligations imposed by ACT 2 – 2018, and other applicable laws, and I acknowledge and accept the consequences of signing this sworn statement.

8. That I certify that I as well as the company, know of our continuous duty to report on any investigation, accusation or conviction against the company, its subsidiary companies, affiliates and/or headquarters, and/or their respective shareholders, directors, associates, officers, executives, principals and/or employees, related to the crimes and undue conducts listed in clause 5 & 6.

9. I certify that neither, the declarant nor the company, its subsidiary companies, affiliates and/or headquarters, and/or their respective shareholders, directors, associates, officers, executives, principals and/or employees, to the best of my knowledge or according to what has been informed to me, has been or is presently debarred, suspended, or excluded from participation by any other state or federal entity.

10. I certify that neither, the declarant nor the company, its subsidiary companies, affiliates and/or headquarters, and/or their respective shareholders, directors, associates, officers, executives, principals and/or employees, to the best of my knowledge or according to what has been informed to me, have incurred nor will we incur in conducts that violate the law, anti-trust federal and state regulations and guidelines, such as agreeing with another company and/or company proponent to set fixed prices, submit proposals or take another action for the purpose of impeding, restricting or limiting free competition; or that may have an adverse or negative impact on the services to be offered to the population.

11. That the above declared is the truth and nothing but the truth

and in Witness Thereof I swear and sign this affidavit on January 24th of 2022 _____

Signature of Declarant

Name of Declarant Theodore O. Will

Position Chief Executive Officer

Company name IPRO

Sworn and subscribed before me by Theodore O. Will whose personal circumstances have been previously stated, and whom I gave faith to know personally/have identified by means of drivers License

In January, 24th of 2022 (location) Lake Success, New York

Notary Public

Sharon M. Malcolm

SHARON M MALCOLM
Notary Public - State of New York
NO. 01MA6171990
Qualified in Nassau County
My Commission Expires Aug 6, 2023

Place seal here

D.5. Quality/Compliance Review Tool

A sample quality/compliance review tool is provided following this page.

D.6. Sample Quality/Compliance Review Report

A sample quality/compliance review report is provided following this page.

Amerihealth Caritas of Louisiana

2019 Compliance Audit

Review Period: April 01, 2018 – March 31, 2019

Final Report Issued December 2019

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

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

ISO 9001:2008 CERTIFIED

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Introduction and Audit Overview

Introduction

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

To meet these federal requirements, the Louisiana Department of Health (LDH) has contracted with IPRO, an EQRO, to conduct annual compliance audits every three years. The 2019 annual compliance audit was a full audit of the MCO's compliance with contractual requirements during the period of April 1, 2018 through March 31, 2019.

This report presents IPRO's findings of the 2019 annual compliance audit for Amerihealth Caritas of Louisiana (ACLA).

Audit Overview

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

The audit included a comprehensive evaluation of ACLA's policies, procedures, files, and other materials corresponding to the following nine contractual domains:

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

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

Specifically, file review consisted of the following six areas:

1. Member Grievances
2. Appeals
3. Informal Reconsiderations
4. Case Management (behavioral and physical health)
5. Credential/Recredentialing
6. Utilization Management

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

Table 1: File Review Sample Sizes

File Type	Sample Size
Member Grievances	15
Appeals	10
Informal Reconsiderations	5
Case Management (physical health)	10
Case Management(behavioral health)	10
Credential/Recredentialing	10
Utilization Management	10

The period of review was April 1, 2018 through March 31, 2019. All documents and case files reviewed were active during this time period.

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

Table 2: Review Determination Definitions

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

The 2019 annual compliance audit consisted of three phases: 1) pre-onsite documentation review, 2) onsite visit, and 3) post-onsite report preparation.

Pre-onsite Documentation Review

To ensure a complete and meaningful assessment of the MCO's policies and procedures, IPRO prepared nine review tools to reflect the areas for audit. These nine tools were submitted to the LDH for approval at the outset of the audit process in April 2019. The tools included the review elements drawn from the state and federal regulations. Based upon the LDH's suggestions, some tools were revised and issued as final. These final tools were submitted to the MCO in April 2019 in advance of the onsite audit.

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

To facilitate the audit process, IPRO provided the MCO with examples of documents that the MCO could furnish to validate its compliance with the regulations. Instructions regarding the file review component of the audit were also

provided, along with a request for the universe of cases for each file review area under review. From the universe of cases, IPRO selected a sample for each area, which was reviewed onsite.

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

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

Onsite Visit

The onsite component of the audit was comprised of a two-day onsite visit, which included a review of elements in each of the nine review tools that were considered less than fully compliant based upon pre-onsite review, as well as file review.

The IPRO audit team visited ACLA on July 10 and 11, 2019, to conduct the interview and file review components of the audit. Staff interviews during the onsite visit were used to further explore the written documentation and to allow the MCO to provide additional documentation, if available. File review, as indicated, was conducted to assess the MCO's implementation of policy in accordance to state standards. MCO staff was given two days from the close of the onsite review to provide any further documentation.

Post-onsite Report Preparation

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

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

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

MCO Summary of Findings

Summary of Findings

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

Table 3: Audit Results by Audit Domain

Audit Domain	Total Elements	Full	Substantial	Minimal	Non-compliance	N/A	% Full[1]
Core Benefits and Services	115	111	0	0	0	4	100%
Provider Network Requirements	184	163	15	5	0	1	89%
Utilization Management	87	87	0	0	0	0	100%
Eligibility, Enrollment, and Disenrollment	13	13	0	0	0	0	100%
Marketing and Member Education	83	80	2	0	0	1	98%
Member Grievance and Appeals	65	65	0	0	0	0	100%
Quality Management	114	113	1	0	0	0	99%
Fraud, Abuse, and Waste Prevention	118	116	0	0	0	2	100%
Reporting	1	1	0	0	0	0	100%
TOTAL	**780**	**749**	**18**	**5**	**0**	**8**	**97%**

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

As presented in **Table 3**, 780 elements were reviewed for compliance. Of the 780, 749 were determined to fully meet the regulations, while 18 substantially met the regulations, 5 minimally met the regulations and none were determined to be non-compliant. Eight elements were "not applicable." The overall compliance score for ACLA was 97% elements in full compliance.

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

It is the expectation of both IPRO and the LDH that ACLA submit a corrective action plan (CAP) for each of the 23 elements determined to be less than fully compliant in **Table 4**, along with a timeframe for completion of the corrective action. Note that ACLA may have implemented corrective actions for some of the areas identified for improvement while the audit was in progress, but these corrective actions will still require a written response since they were made after the period of review. The vast majority of the issues noted related to ACLA's provider network adequacy (20 of the 23 elements rated less than fully compliant) and ACLA's ability to contract with providers in several specialty and sub-specialty areas–a problem prevalent in the Louisiana Medicaid Managed Care program.

Each of the nine review tools and review determinations for each of the elements follow **Table 4**. Note that the yellow highlighting in the element descriptions reflects new language in the state regulations that was added since the 2016 compliance review period.

Table 4: Deficient 2019 Audit Elements

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
Provider Network Requirements					
7.1.4	Network providers must be available within a reasonable distance to members and accessible within an appropriate timeframe to meet the members' medical needs. Standards for distance and time are fully outlined in this Section and in the Provider Network Companion Guide. The MCO shall ensure that providers are available in network within the distance requirements set forth in this Section.	Network Provider Development and Management Plan P/P for Provider Network P/P for Access and Availability	Substantial	This requirement is addressed in the Network Development Plan in section 7.3 Geo Access Requirements of this review. **Recommendation** See recommendations for individual requirements in section 7.3 Geo Access Requirements.	Please see all responses in Section 7.3.
7.1.9	The MCO and its providers shall deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity and provide for cultural competency and linguistic needs, including the member's prevalent language(s) and sign language interpreters in accordance with 42 CFR §438.206(c)(2). MCOs must ensure that effective, equitable, understandable, and respectful	Network Provider Development and Management Plan P/P for Provider Network Provider manual/handbook Provider contracts	Substantial	This requirement is addressed in the Provider Culture and Ethnicity Policy and Procedure and "FAX BLAST Provider Cultural Competency Training." Missing from the documentation is the requirement in bullet point 1 about collecting member demographic data. **Recommendation** The MCO should collect, and document that they collect, demographic data so that the needs of the community can be met.	ACLA will add this requirement to the Provider Culture and Ethnicity Policy (#CPNM 339.450) to ensure and validate that the collection of this demographic data is occurring in order to meet the needs of the community.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs are provided. Assurances shall be achieved by: • Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required); • Assessing the cultural competency of the providers on an ongoing basis, at least annually; • Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender,				

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	parish, etc.; • Assessing provider satisfaction of the services provided by the MCO at least annually; and • Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments.				
7.3.0	The MCO shall comply with the following maximum travel time and/or distance requirements, as specified in the Provider Network Companion Guide. Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval. Such requests should include data on the local provider population available to the non-Medicaid population. If LDH approves the exception, the MCO shall monitor member access to the specific provider type on an ongoing basis and provide the findings to LDH as part of its annual Network	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial	This requirement is addressed in the following requirements of section 7.3 Geo Access Requirements. **Recommendation** See recommendations for individual requirements in section 7.3.	Please see all responses below that responsive to this element.

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	Provider Development Management Plan.				
7.3.1 7.3.1.1 7.3.1.2	Primary Care Providers .1 Travel distance for members living in rural parishes shall not exceed 30 miles; and .2 Travel distance for members living in urban parishes shall not exceed 10 miles	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial	This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 3. A review of geo access reports indicates that time or distance requirements are met for all rural parishes, but not for all urban parishes. **Recommendation** The MCO should improve access to PCPs for their urban members.	The requirement as stated in 7.3 and the Provider Network Companion guide is "The MCO shall comply with the following maximum travel time and/or distance requirements, as specified in the Provider Network Companion Guide." As of 8/12/2019, 99.9% of members in urban areas have access to an Adult or Pediatric PCP within the 20 minute requirement. ACLA is open to adding PCPs as providers' request. ACLA is currently outreaching providers who have been exclusively signed up with one or two health plans to add them to the network.
7.3.2 7.3.2.1 7.3.2.2	Acute Inpatient Hospitals • Travel distance for members living in rural parishes shall not exceed 30 miles; If no hospital is available within 30 miles of a member's residence, the MCO may request, in writing, an exception to this requirement. • Travel distance for members living in urban parishes shall	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial	This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 4. A review of geo access reports indicates that time or distance requirements are met for all rural parishes, but not for all urban parishes. **Recommendation** The MCO should improve access to acute inpatient hospitals for their urban	The requirement as stated in 7.3 and the Provider Network Companion guide is "The MCO shall comply with the following maximum travel time and/or distance requirements, as specified in the Provider Network Companion Guide." As of 8/12/2019, 99.1% of the members in urban

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	not exceed 10 miles.			members.	parishes have access to an acute hospital within the 20 minute requirement. ACLA is contracted with all acute inpatient hospitals at this time. See the attached PH Network Development Service document in the row above.
7.3.3 7.3.3.1 7.3.3.2 7.3.3.3 7.3.3.4	Specialists • Travel distance to each specialty type shall not exceed 60 miles for at least 75% of members; and • Travel distance shall not exceed 90 miles for all members. • Specialists included under this requirement are listed the Provider Network Companion Guide.. LDH reserves the right to add additional specialty types as needed to meet the medical needs of the member population. • Telemedicine may be used to facilitate access to specialists to augment MCO's network or to meet specific needs of a subset of the MCO's membership. If an MCO intends to utilize telemedicine to meet	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial	This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 5. A review of geo access reports indicates that time or distance requirements are not met for all parishes in most specialties. **Recommendation** The MCO should improve member access for most specialties.	Specialty types with gaps include Allergy/Immunology, Dermatology, Endocrinology, Hematology, and Nephrology. Two (2) parishes in Region 7 have gaps for 3 of these specialty types and four parishes in Region 5 have gaps for Endocrinology. Region 6 has the largest gap for four of the specialty types noted above with the exception of Nephrology. Region 8 has gaps for the four specialty types noted above. ACLA is currently outreaching providers who historically only contracted with one or 2 of the MCO(s) to add them to the network which will add PCPs and specialty providers.

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	network adequacy requirements, the MCO's telemedicine utilization must be approved by LDH for this purpose.				
7.3.4 7.3.4.1 7.3.4.2	Lab and Radiology Services • Travel distance shall not exceed 20 miles in urban parishes; and • Travel distance shall not exceed 30 miles for rural parishes.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial	This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 4. A review of geo access reports indicates that time or distance requirements were met for all rural parishes, but not for all urban parishes. **Recommendation** The MCO should improve member access to lab and radiology services in urban parishes. The MCO has indicated that the Geo Access Report only includes stand-alone lab and radiology services and that more lab and radiology services are provided to members that are not counted in the geo access report.	There are multiple hospitals, urgent care centers, and physician offices that provide lab services which are not included in this geo-access mapping. ACLA is also contracted with three large lab companies that work directly with physicians by arranging pick up of testing or lab draws at the physician offices which increases access and compliance for enrollees who are unable or unwilling to drive to a specific lab for lab draws/testing.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
7.3.5 7.3.5.1 7.3.5.2	Pharmacies .1 Travel distance shall not exceed 10 miles in urban parishes; and .2 Travel distance shall not exceed 30 miles in rural parishes.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial	This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 4. A review of geo access reports indicates that time or distance requirements were met for all rural parishes, but not for all urban parishes. **Recommendation** The MCO should improve member access to pharmacies in urban parishes.	ACLA is currently contracted with 1,182 pharmacy locations in Louisiana. Per NCPDP, there are currently nine pharmacies in the parishes with gaps (three in Plaquemines and six in Union). ACLA is contracted with all nine. ACLA is contracted with 71 pharmacies in Region 5 and 213 in Region 1. Only 0.1% of the enrollees in urban parishes do not have access within 20 minutes. Enrollees in all urban parishes, with the exception of Cameron and Plaquemines, have a drive time within 20 minutes to a pharmacy. AmeriHealth Caritas' PerformRx is our pharmacy benefit manager who builds our network to meet members' access needs and provides access to retail and specialty pharmacy providers.
7.3.6 7.3.6.1 7.3.6.2	Hemodialysis Centers .1 Travel distance shall not exceed 10 miles in urban areas; and .2 Travel distance shall not exceed 30 miles in rural areas.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Minimal	This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 4. A review of geo access reports indicates that time or distance requirements were met for some rural parishes and most urban parishes.	Only 1.8% of the enrollees in urban parishes drive more than 20 minutes to this provider type. Among nine urban parishes in Regions 1, 2, 3, 5, 6, and 7, more than 90% of the enrollees have access within the required driving time. These include

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				Recommendation The MCO should improve member access to hemodialysis centers in rural parishes and especially in urban parishes.	Bossier, Caddo, Calcasieu, De Soto, Pointe Coupee, Rapides, St. Bernard, Terrebonne and West Feliciana. The largest percentage of enrollees who drive more than the maximum standard reside in Cameron (Region 5), Grant (Region 6), Lafourche (Region 3), Plaquemines (Region 1), and Union (Region 8) parishes. ACLA is working with providers to expand this level of care. There are 178 providers to date. Two new centers were added to ACLA's network in Quarter 2 2019 in Regions 1 and 6. ACLA continues to work with large providers, i.e. Fresenius, to increase access to these centers. See document above.
7.3.7.2	Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN Nurse Practitioner or CNS in mental health, or LCSW's) and to psychiatrists for members living in urban parishes shall not exceed 15 miles or 30 minutes	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial	A review of geo access reports indicates that time or distance requirements were not met for urban parishes. **Recommendation** The MCO should improve member access to specialized behavioral health providers in urban parishes.	One hundred percent (100%) of enrollees in rural parishes have access to a BHS within 60 minutes, whereas 99.8% of enrollees in urban parishes have access within the standard of 30 minutes. In Plaquemines Parish, 35% of

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	for 90% of such members.				the enrollees need to travel slightly more than the 30 minute standard. ACLA welcomes individual SBHS providers into the network and works with these providers to retain them.
7.3.7.4	Travel distance to ASAM Level 3.3 shall not exceed 30 miles or 60 minutes for 90% of adult members. Maximum time for admission or appointment shall not exceed 10 business days.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial	This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 6. A review of geo access reports indicates that time or distance requirements were not met for urban or rural parishes. Missing from the documentation provided are admissions data. **Recommendation** The MCO should improve member access to ASAM level 3.3. The MCO should record and report admission or appointment times for ASAM level 3.3 **Final Review Determination** Review determination changed to substantial. While time and distance standards are not met LDH has confirmed that MCOs were not required to report admission or appointment times.	Statutory report 359, Measurement 2 addressed the minimum performance thresholds for time of admission or appointment but this was never required and discontinued July 2018. ACLA continues to encourage these provider types to enter the ACLA network. ACLA has reached an agreement with Acadia Healthcare for ASAM Residential for adults and adolescents. ACLA completed contracting and credentialing for a new entity Substance Use Residential program and for existing sites with Addiction Recovery Resources which involved a change of ownership for 3 sites in Metairie and one site in Destrehan, La. These are referenced as Avenues Recovery. ACLA is also working on contracting with

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					a Substance Residential Provider who has historically only accepted commercial pay in the New Orleans area. ACLA completed a project involving outreach to all network Substance Use providers to verify ASAM levels as these provider types added capacity and/or locations without notifying ACLA. Work requests to add or change ASAM levels is in progress. One provider in Ruston became credentialed adding SU Residential services. ACLA is contracted with all Opioid Treatment Program providers with the exception of Choices who has not yet submitted a packet. See BH report above.
7.3.7.5	Travel distance to ASAM Level 3.5 shall not exceed 30 miles or 60 minutes for 90% of adult members and shall not exceed 60 miles or 90 minutes for adolescent members. Maximum time for admission or appointment shall not exceed 10 business days.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial	This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 6. A review of geo access reports indicates that time or distance requirements were not met for urban or rural parishes. Missing from the documentation provided are admissions data.	Same feedback as above.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				Recommendations The MCO should improve member access to ASAM level 3.5. The MCO should also record and report admission or appointment times for ASAM level 3.5. **Final Review Determination** Review determination changed to substantial. While time and distance standards are not met LDH has confirmed that MCOs were not required to report admission or appointment times.	
7.3.7.6	Travel distance to ASAM Level 3.7 co-occurring treatment shall not exceed 60 miles or 90 minutes for 90% of adult members. Maximus time for admission or appointment shall not exceed 10 business days.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial	This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 6. A review of geo access reports indicates that time or distance requirements were not met for urban or rural parishes. Missing from the documentation provided are admissions data. **Recommendation** The MCO should improve member access to ASAM level 3.7 co-occurring treatment. The MCO should record and report admission or appointment times for ASAM level 3.7 co-occurring treatment. **Final Review Determination** Review determination changed to	Same as above.

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
				substantial. While time and distance standards are not met LDH has confirmed that MCOs were not required to report admission or appointment times.	
7.5.3 7.5.3.1 7.5.3.2	**Provider to Member Ratios** • Quarterly GeoAccess reports shall include analysis of provider-to-member ratios in each geographical area as outlined in this Section and the Provider Network Companion Guide. • Member linkages to Primary Care providers shall be submitted to LDH weekly as described in the MCO Systems Companion Guide.	GeoAccess reports Communications to LDH	Minimal	This requirement is addressed in the 348 BH and 220 PH Geo Access Reports. Missing from the reports are provider-to-member ratios. **Recommendation** The MCO should include provider-to-member ratios in the Geo Access Reports. **Final Review Determination** No change in determination. We cannot accept new documents at this stage and the attached document is outside the review period (April 1, 2018 – March 31, 2019).	The Provider Network Companion Guide has the provider-to-member ratios for 12 specialty types, i.e. Allergy/Immunology is 1:100,000. The BH and PH GeoAccess reports include the number of members located in each parish. The number of providers for each provider type is noted on the actual maps. The total number of members divided by the number of that specialty type provides the ratio. The ratios have been analyzed on an annual basis. Based on current reporting templates developed by LDH, the provider-to-member ratio is required quarterly for each parish and this was analyzed in Quarter 2 of 2019.
7.7.4	The MCO shall ensure that providers do not exclude treatment or placement of members for authorized behavioral health services solely	Provider contracts/Manual	Substantial	This requirement is addressed in the ACLA Specialty Care Provider Agreement on page 15. Missing from the documentation provided is explicit mention that the MCO shall ensure that	ACLA is adding the statement that "ACLA shall ensure that providers do not exclude treatment or placement of members for

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	on the basis of state agency (DCFS or OJJ, etc.) involvement or referral.			providers do not exclude treatment for behavioral health services solely on the basis of state agency involvement. **Recommendation** The MCO should include in the policy the requirement that the MCO shall ensure that providers do not exclude treatment or placement of members for authorized behavioral health services solely on the basis of state agency (DCFS or OJJ, etc.) involvement or referral.	authorized behavioral health services solely on the basis of state agency (DCFS or OJJ, etc.) involvement or referral" to the Provider Manual.
7.8.3.4	The MCO shall establish and maintain a provider network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum: • The MCO has signed a contract with providers of the specialty types listed in the Provider Network Companion Guide who accept new members and are available on at least a referral basis; and • The MCO is in compliance with access and availability requirements	P/P for Provider Network P/P for Access to Specialty Providers GeoAccess reports Evidence of signed contracts with listed specialty provider types	Substantial	This requirement is addressed in section 7.3, Geographic Access Requirements.	See above response.
7.8.15.5	Where timely access to covered	P/P provider network	Substantial	This requirement is addressed in the	ACLA will add this to the

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
7.8.15.5.1 7.8.15.5.2	services cannot be ensured due to few or no IHCPs, the MCO will be considered to have met the requirement in paragraph 42 CFR §438.14 (b)(1) if: .1 Indian members are permitted by the MCO to access out-of-state IHCPs; or .2 If this circumstance is deemed to be good cause for disenrollment from the State's Managed Care Program in accordance with 42 CFR §438.56(c).	P/P care coordination Network reports		Provider Accessibility and Availability Standards and Compliance Policy and Procedure on page 5. Missing from the provided documents is an indication of whether members are permitted by ACLA to access out-of-state IHCPs or if this circumstance is deemed to be good cause for disenrollment. **Recommendation** The MCO should address in policy whether: "Indian members are permitted by the MCO to access out-of-state IHCPs; or If this circumstance is deemed to be good cause for disenrollment from the State's Managed Care Program in accordance with 42 CFR §438.56(c)."	Provider Accessibility and Availability Standards and Compliance Policy (#159.201). Also, ACLA has a clinical liaison who completes single case agreements for members who need care and/or treatment out of the state.
7.9.3.1	The MCO shall ensure network capacity sufficient to meet the specialized needs of individuals with dual diagnosis of behavioral health and developmental disabilities, including autism spectrum disorders. The plan shall specifically assess the extent to which the MCO's in-state network is sufficient to meet the needs of this population.	Provider Network Development and Management Plan	Minimal	This requirement was not addressed explicitly in the documentation provided. **Recommendation** The MCO should assess the network capacity to address the needs of individuals with dual diagnosis of behavioral health and developmental disabilities.	ACLA will revise the current language to specifically state "specialized needs of individuals with dual diagnosis of behavioral health and developmental disabilities, including autism spectrum disorders" in several documents. ACLA has increased the provider types of Applied Behavioral Analysis services from 29 when the service was carved in to the plan in March 2018 to a current number of 54 providers. These services are designed for members with specialized needs of

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
					behavioral health and developmental disabilities include autism spectrum disorders.
7.9.3.2	Providers specializing in serving individuals with dual diagnosis of behavioral health and developmental disabilities shall be clearly identified in the provider directory.	Provider Network Development and Management Plan Provider Directory	Minimal	This requirement was not addressed explicitly in the documentation provided. **Recommendation** The MCO should clearly identify whether a provider is specialized in serving individuals with a dual diagnosis of behavioral health and developmental disabilities.	In addition to the above statement, ACLA will work to add specifications to clearly identify this in the provider directory.
7.14.7	The MCO shall not delegate credentialing of specialized behavioral health providers unless approved by LDH in advance.	P/P for credentialing & recredentialing	Minimal	This requirement is addressed in the Credentialing /Re-credentialing of Practitioners. Missing from the supplied documents is the requirement that the MCO shall not delegate credentialing of specialized behavioral health providers unless approved by LDH in advance. **Recommendation** The MCO should indicate in the policy that they will not delegate credentialing of specialized behavioral health providers unless approved by LDH in advance.	ACLA does not have any specialized behavioral health providers delegated at this time. However, ACLA will add this to the Credentialing and Recredentialing of Practitioners Policy (#CP 210.104).
Marketing and Member Education					
12.14.1.2	Web-based searchable, web-based machine readable, online directory for members and the public;	P/P for Provider Directory Provider Directory (website link)	Substantial	This requirement is partially addressed in the provider directory. The MCO does not yet have a machine readable online directory.	ACLA is moving ahead with ensuring that the provider directory within the Member section of the website is machine readable. While we do not have an exact

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
				Recommendation It is recommended that the MCO work to make the online directory" machine readable". Post-onsite, the MCO stated that they are working to implement machine readability by creating a link to the JSON file (which is machine readable) within the Member component of the Website.	timeframe for implementation, we are moving forward as expeditiously as possible to make this happen.
12.14.4.1	Names, locations, telephone numbers of, website URLs, specialties, whether the provider is accepting new members, and cultural and linguistic capabilities by current contracted providers by each provider type specified in this RFP in the Medicaid enrollee's service area. Cultural and linguistic capabilities shall include languages offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competency training. The provider directory shall also indicate whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment;	P/P for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)	Substantial	This requirement is partially addressed in the New Provider/Practitioner Load /Data Update-Change Policy. Incorporation of whether a provider has completed cultural competency training is not found in the online provider directory **Recommendation** The MCO should work to include whether a provider has completed cultural competency training in their provider directory. Post onsite, the MCO stated that they are working to load this information into FACETS, which captures information about providers. This will populate the online directory, which has this search functionality in the member portal, through the Advanced Search option.	This information is already being captured. However, ACLA is working to have this it populated in the online directory.
Quality Management					

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
14.9.3.2	Member rights and confidentiality, including advance directives and informed consent;		Substantial	Confidentiality is noted as a review element in the 356 Provider Monitoring Strategy on page 1 but is not an element in the review tool. **Recommendation** ACLA should explicitly add maintenance of "member confidentiality" in the provider monitoring review tool, perhaps in the Member Rights section of the tool that covers release of information, page 8.	ACLA has incorporated the maintenance of "member confidentiality to the review tool. See the document attached below. The template is being used effective 8/12/2019.

MCO Final Audit Tools

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

Core Benefits and Services

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
6.4	**Behavioral Health Services**					
6.4.5 6.4.5.1	**Permanent Supportive Housing** LDH partners with the Louisiana Housing Authority (LHA) to co-manage the Louisiana Permanent Supportive Housing (PSH) program. PSH provides deeply affordable, community-integrated housing paired with tenancy supports that assist persons with disabilities to be successful tenants and maintain stable housing. The Louisiana PSH program is a cross-disability program that provides access to over 3,300 affordable housing units with rental subsidies statewide. In Louisiana, PSH services are reimbursed under several Medicaid HCBS programs, and under specialized behavioral health State Plan services where it is billed as a component of CPST and PSR. However, Medicaid Managed Care members must meet PSH program eligibility criteria, in addition to medical necessity criteria for services in order to participate in PSH http://new.dhh.louisiana.gov/index.cfm/page/1732/n/388 Overall management of the PSH program is centralized within LDH and final approval for members to participate in PSH is made by the LDH PSH program staff. For the Louisiana PSH program, the MCO shall:					
6.4.5.1.1	Provide outreach to qualified members with a potential need for PSH;	Member letters Member handbook		Full	This requirement is addressed in the ACLA Member Handbook, page 20, bullet 4 in right	

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
		P/P member education			column Website: http://www.amerihealthcaritasla.com/member/eng/benefits/behavioral.aspx Policy 156.900 Continuity to BH Care Coordination with Primary Care and BH Provider, page 2, number 7. PSH Workflow and process.	
6.4.5.1.2	Assist members in completing the PSH program application;	Member letters Member handbook P/P member education		Full	This requirement is addressed in Policy 156.801 Care Coordination, page 3, bullet 4, on ACLA Member Handbook and Process.	
6.4.5.1.3	Within one (1) working day of request by designated LDH PSH program staff, provide accurate information about status of eligibility assessment, determination, and recertification;	Communications to LDH P/P education		Full	This is not currently a function of the MCOs. This requirement is addressed in the ACLA Member Handbook Communications to LDH, Policy and Procedure education.	
6.4.5.1.8	Report on PSH outreach monthly and quarterly using a format to be provided by the LDH PSH program manager; and	Completed LDH template		Full	This is not currently a function of the MCOs. This requirement is addressed in reviewing the PSH Workflow.	
6.4.5.2	To assure effective accomplishment of the responsibilities required per Section 6.4.5.1 the MCO shall:					
6.4.5.2.1	Identify a PSH program liaison, to be approved by LDH, to work with LDH PSH program staff to assure effective performance of MCO responsibilities and requirements, effective implementation and delivery of PSH services, and to address problems or issues that may arise.	Organizational chart		Full	This requirement is addressed in the ACLA Liaison List.	
6.4.9	The MCO shall provide guidelines, education and training, and consultation to PCPs to support the provision of basic behavioral health services in the primary care setting.	Training slides P/P provider education Provider handbook		Full	This requirement is addressed in the ACLA Provider Handbook, Behavioral Health Services section, page 51, Behavioral Health Provider Toolkit, SBIRT section, page 52, Policy 156.900 Continuity for Behavioral Healthcare and Care Coordination with Primary Care; and Behavioral Health Providers, page 19, numbers 19 – 21; and	

Core Benefits and Services						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					2018 IHCM Program Description, page 37.	
6.4.9.1	The MCO shall ensure network providers utilize behavioral health screening tools and protocols consistent with industry standards. The MCO shall work to increase screening in primary care for developmental, behavioral, and social delays, as well as screening for child maltreatment risk factors, trauma, and adverse childhood experiences (ACEs). The MCO may provide technical assistance to providers, incentives, or other means to increase screening for behavioral health needs in primary care.	Provider handbook Provider education materials Provider contracts P/P provider education		Full	This requirement is addressed in the Behavioral Health Provider Toolkit – the entire manual is a tool to educate providers on screenings and protocols. Important Billing Updates – reimbursement for screenings, page 3; Policy 156.900 - Continuity for Behavioral Healthcare and Care Coordination with Primary Care and Behavioral Health Providers, page 4, number 22; and Network Development Management Plan 2018 Resubmit, pages 16, 20, 24, 43, and 44.	
6.4.9.2	The MCO shall work to increase provider utilization of consensus guidelines and pathways for warm handoffs and/or referrals to behavioral health providers for children who screen positive for developmental, behavioral, and social delays, as well as child maltreatment risk factors, trauma, and adverse childhood experiences (ACEs). The MCO shall work to increase the percentage of children with positive screens who: 1) receive a warm handoff to and/or are referred for more specialized assessment(s) or treatment and 2) receive specialized assessment or treatment.	P/P provider education Provider handbook		Full	This requirement is addressed in the Anxiety Disorders eLearning Module - https://amerihealthcaritas.adobeconnect.com/_a1050101005/anxietydisordersla/ (Notice in Provider Newsletter, Summer 2018) Depression Disorders eLearning Module - https://amerihealthcaritas.adobeconnect.com/_a1050101005/depressionacla/ (Notice in Provider Newsletter, March 2018), and ACLA Provider Handbook January 2019, pages 72-73.	
6.4.10	Develop crisis intervention and stabilization services to better manage behavioral health issues in the community. The MCO shall maintain an active role in managing the process to ensure resolution of behavioral health crises in the community and referral to and assistance with placement in behavioral health services required by the individual in need. Regional crisis community collaborations consist of an array of public and private partners such as law	P/P behavioral integration Communications with community agencies		Full	This requirement is addressed in the BH Crisis Center 1-pager, which has not been approved, and To be Determined by the State and verified by LDH and ACLA (Dr. Mueller).	

Core Benefits and Services						
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	enforcement, emergency department directors, psychiatric acute unit directors, coroners, behavioral health advocates, and peer supports. The MCO shall familiarize itself with the local crisis collaborative and work with it to facilitate crisis resolution.					
6.8	**Emergency Medical Services and Post Stabilization Services**					
6.8.1 6.8.1.1	**Emergency Medical Services** The MCO shall provide that emergency services, including those for specialized behavioral health, be rendered without the requirement of prior authorization of any kind. The MCO must cover and pay for emergency services regardless of whether the provider that furnishes the emergency services has a contract with the MCO. If an emergency medical condition exists, the MCO is obligated to pay for the emergency service.	Member handbook P/P ER services		Full	This requirement is addressed in the ACLA Member Handbook, page 8 (Emergency Care Services Covered) and page 33; and 153.905 (Emergency Room Services), page 1-4. 153.003 Standard and Urgent Prior Authorization (Pre-Service) Authorization Attachment A. 153.003 Standard and Urgent Prior (Pre-Service) Authorization 2019ML, page 5, and Policy No. 153.904 Authorization for Out-of-Network Practitioners and Providers 2019, page 1.	
6.8.1.2	The MCO shall advise all Medicaid MCO members of the provisions governing in and out-of-service area use of emergency services as defined in the Glossary.	Member handbook		Full	This requirement is addressed in the ACLA Member Handbook on page 31 (Getting Care Away From Home).	
6.8.1.3	The MCO shall not deny payment for treatment when a representative of the entity instructs the member to seek emergency services.	Member handbook P/P Member services		Full	This requirement is addressed in the 526-024 Accessing Emergent and Urgent Care and 153.905 Emergency Room Services on page 1.	
6.8.1.4	The MCO shall not deny payment for treatment obtained when a member had an emergency medical condition as defined in 42 CFR §438.114(a), nor limit what constitutes an emergency behavioral health condition on the basis of behavioral health diagnoses or symptoms.	Member handbook P/P emergency services		Full	This requirement is addressed in the ACLA Provider Handbook, Prior Authorization/Notification for ER Services/Payment on page 53, and 153.905 Emergency Room Services on page 2.	
6.8.1.5	The attending emergency physician, Licensed Mental Health Provider (LMHP), or the provider	Provider handbook P/P Care coordination		Full	This requirement is addressed in the ACLA Provider Handbook on page 54 and 153.905	

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	actually treating the member shall determine when the member is sufficiently stabilized for transfer or discharge and that determination is binding on the MCO for coverage and payment.				Emergency Room Services.	
6.8.1.6	If there is a disagreement between a hospital or other treating facility and an MCO concerning whether the member is stable enough for discharge or transfer from the Emergency Department (ED), the judgment of the attending emergency physician(s) at the hospital or other treating facility at the time of discharge or transfer prevails and is binding on the MCO. This subsection shall not apply to a disagreement concerning discharge or transfer following an inpatient admission once the member is stabilized.	P/P Coordination of services Communications to hospital		Full	This requirement is addressed in 153.905 Emergency Room Services on pages 2-3.	
6.8.1.7	The MCO will include in the proposal a plan to provide care in the most appropriate and cost-effective setting. The plan should specifically address non-emergent use of hospital Emergency Departments. Strategies of interest to LDH include but are not limited to access to primary care services through medical homes, urgent care and retail clinics; and, interventions targeted to super-utilizers, such as patients with sickle cell disease, chronic pain, dental, and/or behavioral health conditions.	P/P Coordination of Services Quality of core plan Member handbook		Full	This requirement is addressed in 153.002 Concurrent Review on page 1. 2018 Integrated Health Care Program Description, section Services, on page 32, RROT on page 54, and 2018 IHCM_Program Evaluation FINAL on page 102. ACLA Clinical Quality, Improvement Activity: Ambulatory Care: ED Visits/1,000 Member Months.	
6.8.1.8	The MCO shall be responsible for educating members and providers regarding appropriate utilization of ED services, including behavioral health emergencies.	Member & provider handbook Educational materials		Full	This requirement is addressed in the ACLA Provider Handbook on page 53 and the ACLA "Is this an Emergency?" bi-fold/handout.	
6.8.1.9	The MCO shall monitor emergency services utilization by provider and member and shall have routine means for redressing inappropriate emergency department utilization. For utilization review, the test for appropriateness of the request	P./P Emergency services Member handbook		Full	This requirement was addressed in the 2018 Integrated Health Care Program Description, section Services on page 32, and RROT on page 54; 2018 IHCM_Program Evaluation FINAL on	

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	for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For the purposes of this contract, a prudent layperson is a person who possesses an average knowledge of health and medicine.				page 102; ACLA Clinical Quality Improvement Activity: Ambulatory Care: ED Visits/1,000 Member Months and Emergency Room Utilization Report;	
6.8.1.10	A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	Member handbook		Full	This requirement is addressed in the ACLA Member Handbook on page 8.	
6.8.2 6.8.2.1.	**Post Stabilization Services** As specified in 42 CFR §438.114(e) and 42 CFR §422.113(c)(2)(i), (ii) and (iii), the MCO is financially responsible for post-stabilization care services obtained within or outside the MCO that are:					
6.8.2.1.1	Pre-approved by a network provider or other MCO representative; or	P./P post stabilization services		Full	This requirement is addressed in 153.905 Emergency Room Services on pages 2-3 (policy in 08 – UM folder).	
6.8.2.1.2	Not preapproved by a network provider or other MCO representative, but:	P./P post stabilization services		Full	This requirement is addressed in 153.905 Emergency Room Services on pages 2-3. (policy in 08 – UM folder).	
6.8.2.1.2.1	Administered to maintain the member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services or	P./P post stabilization services		Full	This requirement is addressed in 153.905 Emergency Room Services on pages 2-3 (Policy in 08 – UM folder).	
6.8.2.1.2.2	Administered to maintain, improve or resolve the member's stabilized condition if the MCO: • Does not respond to a request for pre-approval within one hour; • Cannot be contacted; or • MCO's representative and the treating physician cannot reach an agreement concerning the member's care and a network physician is not available for consultation. In this situation, the	P./P post stabilization services Provider handbook		Full	This requirement is addressed in the ACLA Provider Handbook on page 45 and 153.905 Emergency Room Services pages 2-3 (policy in 08 – UM folder).	

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	MCO must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of (422.133(c)(3)) is met.					
6.8.2.2	The MCO's financial responsibility for post-stabilization care services that it has not pre-approved ends when:	P./P post stabilization services				
6.8.2.2.1	A network physician with privileges at the treating hospital assumes responsibility for the member's care;	P./P post stabilization services		Full	This requirement is addressed in 153.905 Emergency Room Services on pages 2-3 (policy in 08 – UM folder).	
6.8.2.2.2	A network physician assumes responsibility for the member's care through transfer;	P./P post stabilization services		Full	This requirement is addressed in 153.905 Emergency Room Services on pages 2-3 (policy in 08 – UM folder).	
6.8.2.2.3	A representative of the MCO and the treating physician reach an agreement concerning the member's care; or	P./P post stabilization services		Full	This requirement is addressed in 153.905 Emergency Room Services on pages 2-3 (policy in 08 – UM folder).	
6.8.2.2.4	The member is discharged.	P./P post stabilization services		Full	This requirement is addressed in 153.905 Emergency Room Services on pages 2-3 (policy in 08 – UM folder).	
6.19	**Services for Special Populations**					
6.19.1	Special Health Care Needs (SHCN) population is defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care approaches. For the behavioral health population, individuals with special health care needs include:					
6.19.1.1	Individuals with co-occurring mental health and substance use disorders;					
6.19.1.2	Individuals with intravenous drug use;					
6.19.1.3	Pregnant women with substance use disorders or co-occurring disorders including but not limited to pregnant women who are using alcohol, illicit or					

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	licit drugs such as opioid and benzodiazepines or at risk of delivering an infant affected by neonatal abstinence syndrome (NAS) or fetal alcohol syndrome;					
6.19.1.4	Individuals with substance use disorders who have dependent children;					
6.19.1.5	Children with behavioral health needs in contact with other child serving systems including OJJ, DCFS, or the judicial system, and not enrolled in CSoC;					
6.19.1.6	Nursing facility residents approved for specialized behavioral health services recommended as a result of PASRR Level II determination;					
6.19.1.7	Adults, 18 years or older, receiving mental health rehabilitation services under the state plan and children/youth who qualify for CSoC as assessed by the CSoC program contractor and have declined to enter or are transitioning out of the CSoC program.					
6.19.1.8	Individuals with 2 or more inpatient or 4 or more ED visits within the past 12 months;					
6.19.1.9	Individuals with co-occurring behavioral health and developmental disabilities;					
6.19.1.10	Individuals diagnosed with Autism Spectrum Disorder (ASD) or at risk of an ASD diagnosis;					
6.19.1.11	Newly diagnosed adolescents and young adults, 15-30 years of age, who experience first signs of symptom onset for serious mental illness, such as schizophrenia, bipolar disorder, and/or major depression; and					
6.19.1.12	Persons living with HIV/AIDS and who are in need of mental health or substance use early intervention, treatment, or prevention services.					
6.19.2	The MCO shall identify members with special health care needs within ninety (90) days of	HRA P/P members with Special		Full	This requirement is addressed in 156.202 Integrated Health Care Management	

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	receiving the member's historical claims data (if available). LDH may also identify special healthcare members and provide that information to the MCO. The LMHP or PCP can identify members as having special needs at any time the member presents with those needs. The MCO must assess those members within ninety (90) days of identification, with the exception of individuals referred for PASRR Level II, who shall be evaluated within federally required timelines as per Section 6.38.5.4. The assessment must be done by appropriate healthcare professionals. Assessments that determine a course of treatment or regular care monitoring as appropriate shall result in a referral for case management.	Health Needs Documentation of assessment conducted Includes Case Management File Review			Referral/Trigger Criteria and Procedure section, page 4-5, 526-021 New Member Education and Communication section, page 3, New Member Welcome Call section, and page 4, number 6, bullet 3. **BH CM FILE REVIEW:** **Eleven (11) cases were reviewed** **One (1) case excluded (not in CM)** **Ten (10) cases were compliant.** **COMPLEX CM FILE REVIEW:** **Twelve (12) cases were reviewed** **Two (2) cases excluded (both UTR)** **Ten (10) cases were compliant.**	
6.19.3	The mechanisms for identifying members with special health care needs (SHCN) that require an assessment to determine if a course of treatment or regular care monitoring is needed are as follows: .1 The MCO shall utilize Medicaid historical claims data (if available) to identify members who meet MCO, LDH approved, guidelines for SHCN criteria. .2 MCO LMHPs and PCPs shall identify to the MCO those members who meet SHCN criteria. .3 Members may self-identify to either the Enrollment Broker or the MCO that they have special health care needs. The Enrollment Broker will provide notification to the MCO of members who indicate they have special health care needs. .4 Members may be identified by LDH and that information provided to the MCO.	P/P members with Special Health Needs Documentation of assessment conducted Includes Case Management File Review		Full	This requirement is addressed in the 156.202 IHCM Referral/Trigger Criteria Procedure (pages 2, 3 – 5). **BH CM FILE REVIEW:** **Eleven (11) cases were reviewed** **One (1) case excluded (not in CM)** **Ten (10) cases were compliant.** **COMPLEX CM FILE REVIEW:** **Twelve (12) cases were reviewed** **Two (2) cases excluded (both UTR)** **Ten (10) cases were compliant.**	
6.19.4	**Individualized Treatment Plans and Care Plans**	P/P Individual Treatment		Full	This requirement is addressed in 156.201	

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	All SHCN members shall be referred for, and if found eligible, offered case management, including an individualized treatment plan developed by the treating provider(s) and a person-centered plan of care developed by the MCO care manager. The individualized treatment plans must be:	Plans CM records Treatment &/or care plans Includes Case Management File Review			Complex Case Management Standards of Practice, Individualized Treatment Plans and Care Plans section, page 7. **BH CM FILE REVIEW:** **Eleven (11) cases were reviewed** **One (1) case excluded (not in CM)** **Ten (10) cases were compliant.** **COMPLEX CM FILE REVIEW:** **Twelve (12) cases were reviewed** **Two (2) cases excluded (both UTR)** **Ten (10) cases were compliant.**	
6.19.4.1	Developed by the member's primary care provider and/or other lead provider as appropriate, with member participation, and in consultation with any specialists caring for the member. For SHCN members, the treatment plan shall be submitted to the member's MCO no later than 30 days following the completion of the initial assessment or annual reassessment.	Treatment plan P/P Individual Treatment Plans Documentation of communication Includes Case Management File Review		Full	This requirement is addressed in 156.201 Complex CM Standards of Practice, Individualized Treatment Plans and Care Plans section, page 7, paragraphs 3-6, page 16-25; BH UM Notification for BH Services and Treatment Plan Workflow section, page 1. **BH CM FILE REVIEW:** **Eleven (11) cases were reviewed** **One (1) case excluded (not in CM)** **Ten (10) cases were compliant.** **COMPLEX CM FILE REVIEW:** **Twelve (12) cases were reviewed** **Two (2) cases excluded (both UTR)** **Ten (10) cases were compliant.**	
6.19.4.2	In compliance with applicable quality assurance and utilization management standards:	P/P Individual Treatment Plans				
6.19.4.3	Reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's circumstances or needs change significantly, or at the request of the member; and	P/P Individual Treatment Plans Plan of Care		Full	This requirement is addressed by reviewing 156.201 Complex Care Management Standards of Practice Individualized Treatment Plans and Care Plans, page 7,	

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		Includes Case Management File Review			paragraphs 3-6. **BH CM FILE REVIEW:** **Eleven (11) cases were reviewed** **One (1) case excluded (not in CM)** **Ten (10) cases were compliant.** **COMPLEX CM FILE REVIEW:** **Twelve (12) cases were reviewed** **Two (2) cases excluded (both UTR)** **Ten (10) cases were compliant.**	
6.19.4.4	A person-centered integrated plan of care developed by the MCO care manager shall be completed within thirty (30) calendar days of provider treatment plan development that includes all medically necessary services including specialized behavioral health services and primary care services identified in the member's treatment plans (individualized treatment plans are developed by the provider(s)) and meet the requirements above.	P/P Individual Treatment Plans Plan of Care		Full	This requirement is addressed in 156.201 Complex Care Management Standards of Practice Individualized Treatment Plans and Care Plans, page 7, paragraph 4.	
6.28	**Care Management**					
6.28.1	Care management is defined as the overall system of medical management, care coordination, continuity of care, care transition, chronic care management, and independent review. The MCO shall ensure that each member has an ongoing source of primary and/or behavioral healthcare appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating Medicaid covered services provided to the member.	CM records Member Handbook		Full	This requirement is addressed in 156.201 Complex Care Management Standards of Practice Section: Case Management, page 1, 156.900 Continuity for Behavioral Healthcare and Care Coordination with Primary Care and Behavioral Health Providers, Purpose, page 5-8.	
6.28.2 6.28.2.1	The MCO shall be responsible for ensuring: Member's healthcare needs and services/care are planned and coordinated through the MCO PCP and/or behavioral health provider;	P/P member Services Provider handbook Includes Care Management File Review	-	Full	This requirement is addressed in the ACLA Provider Handbook, page 40, 156.900 Continuity for Behavioral Healthcare and Care Coordination with Primary Care and Behavioral Health Providers, Purpose, page	

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					5-8. **BH CM FILE REVIEW:** **Eleven (11) cases were reviewed** **One (1) case excluded (not in CM)** **Ten (10) cases were compliant.** **COMPLEX CM FILE REVIEW:** **Twelve (12) cases were reviewed** **Two (2) cases excluded (both UTR)** **Ten (10) cases were compliant.**	
6.28.2.2	Accessibility of services and promoting prevention through qualified providers and medical home practices in accordance with 42 CFR §438.6(k) which requires the provision for reasonable and adequate hours of operation including 24 hour availability of information, referral, and treatment for emergency medical conditions; and	P/P member Services Call center documentation		Full	This requirement is addressed in 526-003 Contact Center Scope Member Services.	
6.28.2.3	Care coordination and referral activities, in person or telephonically depending on member's acuity, incorporate and identify appropriate methods of assessment and referral for members requiring both medical and behavioral health services. These activities must include scheduling assistance, monitoring and follow-up for member(s) requiring medical services and coordination for members requiring behavioral health services.	CM records P/P for care coordination Includes Care Management File Review		Full	This requirement is addressed in 156.201 Complex Care Management Standards of Practice, pages 4, 7D, 8E, and 8J. **BH CM FILE REVIEW:** **Eleven (11) cases were reviewed** **One (1) case excluded (not in CM)** **Ten (10) cases were compliant.** **COMPLEX CM FILE REVIEW:** **Twelve (12) cases were reviewed** **Two (2) cases excluded (both UTR)** **Ten (10) cases were compliant.**	
6.28.2.4	Patients with a condition that causes chronic pain and have five (5) or more ED visits in the most recent 12-month period for chief complaint of pain are contacted by the MCO for a pain management plan and this plan will be shared with the patients' PCP, the patient, and relevant ED staff	Pain management plans P/P for care coordination Includes Care Management File Review		Full	This requirement is addressed in 156.300 Care Management Care Coordination Blended Model for Disease Management, page 5 of Attachment A: Evidence-Based Guidelines (https://www.sign.ac.uk/assets/sign136.pdf); Pain Management Workflow	

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					Emergency Room Outreach Workflow. **BH CM FILE REVIEW:** **Eleven (11) cases were reviewed** **One (1) case excluded (not in CM)** **Ten (10) cases were compliant.** **COMPLEX CM FILE REVIEW:** **Twelve (12) cases were reviewed** **Two (2) cases excluded (both UTR)** **Ten (10) cases were compliant.**	
6.30	**Care Coordination, Continuity of Care, and Care Transition**					
6.30.0	The MCO shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to MCO members. The MCO shall establish a process to coordinate the delivery of core benefits and services with services that are reimbursed on a fee-for-service basis by LDH, provided by LDH's dental benefit program manager, or provided by community and social support providers. The MCO shall ensure member-appropriate provider choice within the MCO and interaction with providers outside the MCO. Continuity of care activities shall ensure that the appropriate personnel, including the service providers, are kept informed of the member's treatment needs, changes, progress or problems. These MCO activities and processes shall be demonstrated via workflows with specific decision points and provided to LDH by January 11, 2016. Continuity of care activities shall provide processes by which MCO members and network and/or non-network provider interactions are effective and shall identify and address those that	P/P for care coordination P/P for PCP choice Member survey Detailed Workflows		Full	This requirement is addressed in 156.701 – Coordination with Other Healthcare and Non-healthcare Services, paragraph 1; 156.301 – Care Transition: Plan or Provider Change, paragraph 1; 153.706L Continuity of Care, page 1-6; 156.900 Continuity for Behavioral Healthcare and Care Coordination with Primary Care and Behavioral Health Providers, pages 1, 5-8, 14, and 15; 156.300 Care Management and Care Coordination Blended Model for Disease Management, page 4, last paragraph, and page 5, paragraphs 2 and 3; 156.701 Coordination With Other Healthcare and Non-healthcare Services, page 6-7. Aunt Bertha website: https://aclastaff.auntbertha.com/	

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	are not effective. The MCO shall ensure that service delivery is properly monitored through member surveys, medical and treatment record reviews, and EOBs to identify and overcome barriers to primary and preventive care that a MCO member may encounter. Corrective action shall be undertaken by the MCO on an as needed basis and as determined by LDH.					
6.30.1	The MCO shall be responsible for the coordination and continuity of care of healthcare services for all members consistent with 42 CFR §438.208. In addition, the MCO shall be responsible for coordinating with the Office of Citizens with Developmental Disabilities for the behavioral health needs of the I/DD co-occurring population.	P/P for care coordination		Full	This requirement is addressed in 156.701 – Coordination with Other Healthcare and Non-healthcare Services, Section: Procedure, page 4; 156.900 Continuity for Behavioral Healthcare and Care Coordination with Primary Care and Behavioral Health Providers, pages 3 and 8.	
6.30.2	The MCO shall implement LDH approved care coordination and continuity of care policies and procedures that meet or exceed the following requirements:					
6.30.2.1	Ensure a best effort is made to conduct an initial screening of the member's needs within ninety (90) days of their enrollment date for all new members. If the initial attempt is unsuccessful, subsequent attempts shall be made within the ninety (90) day time period;	P/P for care coordination Includes Care Management File Review		Full	This requirement is addressed in 156.202 Integrated Health Care Management Referral/Trigger Criteria (page 4 of 9); 153.706L Continuity of Care, pages 4-5; 526-021 New Member Education and Communication, New Member Welcome Call, page 3, page 4, number 1, and process. **BH CM FILE REVIEW:** **Eleven (11) cases were reviewed** **One (1) case excluded (not in CM)** **Ten (10) cases were compliant.** **COMPLEX CM FILE REVIEW:** **Twelve (12) cases were reviewed** **Two (2) cases excluded (both UTR)** **Ten (10) cases were compliant.**	
6.30.2.2	Ensure that each member has an ongoing source	P/P for care coordination		Full	This requirement is addressed in member	

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	of preventive and primary care appropriate to their needs;	Includes Care Management File Review			handbook section: Coordinated Health Care, pages 2 and 13; and 153.706L Continuity of Care, page 4-5 (policy in 08 – UM folder). **BH CM FILE REVIEW:** **Eleven (11) cases were reviewed** **One (1) case excluded (not in CM)** **Ten (10) cases were compliant.** **COMPLEX CM FILE REVIEW:** **Twelve (12) cases were reviewed** **Two (2) cases excluded (both UTR)** **Ten (10) cases were compliant.**	
6.30.2.3	Ensure each member is provided with information on how to contact the person designated to coordinate the services the member accesses;	P/P for care coordination Includes Care Management File Review		Full	This requirement is addressed in Policy 156.201 – Complex Care Management Standards of Practice – page 13, and member handbook, page 3-23; 153.706L Continuity of Care Policy, page 4-5 (policy in 08 – UM folder). **BH CM FILE REVIEW:** **Eleven (11) cases were reviewed** **One (1) case excluded (not in CM)** **Ten (10) cases were compliant.** **COMPLEX CM FILE REVIEW:** **Twelve (12) cases were reviewed** **Two (2) cases excluded (both UTR)** **Ten (10) cases were compliant.** **RECOMMENDATION:** The MCO should mail a Notification Letter to member when there is a CM change with CM contact information, in addition to telephonic notification.	ACLA's Intensive Health Care Management (IHCM) Department is actively addressing the recommendation as evidenced by: 1. The attached member notification letter that is being drafted to inform members when their assigned care manager has changed. 2. The letter will be routed for appropriate reviews, including LDH. 3. Once approved, the letter will be put into use. 4. IHCM policy and procedure will be

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						updated to include process of mailing letter of notification. 5. All Case Management Staff will be in-serviced on utilization and purpose of this letter. A draft of the letter is attached below.
6.30.2.4	Coordinate care between network PCPs and specialists; including specialized behavioral health providers;	P/P for care coordination		Full	This requirement is addressed in 156.900 – Continuity for BH, MCO Responsibilities section, member handbook, page 3-23; 153.706L Continuity of Care Policy, page 4-5 (policy in 08 – UM folder).	
6.30.2.5	Coordinate care for out-of-network services, including specialty care services;	P/P for care coordination		Full	This is addressed in Policy 156.701 – Coordination with Other Healthcare and Non-healthcare Services, Procedures section, page 6; member handbook, page 3-23; 153.706L Continuity of Care Policy, page 4-5 (policy in 08 – UM folder); 153.904L Authorization of Out-of-Network Practitioners and Providers, page 3-4.	
6.30.2.6	Coordinate MCO provided services with services the member may receive from other health care providers;	P/P for care coordination		Full	This requirement is addressed in 156.701 – Coordination with other Healthcare and Non-healthcare Services –paragraph 1; 153.706L Continuity of Care Policy, page 4-5 (policy in 08 –UM folder).	
6.30.2.7	Upon request, share with LDH or other health care entities serving the member with special health care needs the results and identification and assessment of that member's needs to prevent	P/P for care coordination		Full	This requirement is addressed in 156.701 – Coordination with Other Healthcare and Non-healthcare Services, paragraph 1; 153.706L Continuity of Care Policy, page 4-5	

Core Benefits and Services						
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	duplication of those activities;				(policy in 08 –UM folder).	
6.30.2.8	Ensure that each provider furnishing services to the member maintains and shares the member's health record in accordance with professional standards;	P/P for care coordination Provider Handbook		Full	This requirement is addressed in 156.300 – Care Management and Care Coordination Blended Model of Disease Management, page 5; and 153.706L Continuity of Care Policy, page 3-4 (policy in 08 – UM folder).	
6.30.2.9	Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164, and other applicable state or federal laws;	P/P for care coordination		Full	This requirement is addressed in Policy 156.701 – Coordination with Other Healthcare and Non-healthcare Services, page 1; and 153.706L Continuity of Care Policy page 3-4 (policy in 08 – UM folder).	
6.30.2.10	Maintain and operate a formalized hospital and/or institutional discharge planning program;	P/P for care coordination Includes Care Management File Review		Full	This requirement is addressed in Policy 156.800 – Care Transition Discharge Planning, entire policy; and 153.002 Concurrent Review Policy, page 3-6. **BH CM FILE REVIEW:** **Eleven (11) cases were reviewed** **One (1) case excluded (not in CM)** **Ten (10) cases were compliant.** **COMPLEX CM FILE REVIEW:** **Twelve (12) cases were reviewed** **Two (2) cases excluded (both UTR)** **Ten (10) cases were compliant.**	
6.30.2.11	Coordinate hospital and/or institutional discharge planning that includes post-discharge care as appropriate, including aftercare appointments, following an inpatient, PRTF, or other out-of-home stay and; assure that prior authorization for prescription coverage is addressed and or initiated before patient discharge. The MCO must have policies and procedures requiring and assuring that:	P/P for care coordination Includes Care Management File Review		Full	This requirement is addressed in 6.30.2.11 ACLA BH Pharmacy Discharge Template and Process, entire document; BH UM BH IP Discharge review workflow, entire document; 156.800 (entire policy), page 1, paragraphs 4 and 5, and page 2, paragraphs 1 and 2; 151.103 Managing Medications (entire document); 153.002 Concurrent Review Policy, page 3-6; and UM.004L PRTF Policy, page 1-7.	

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					BH CM FILE REVIEW: **Eleven (11) cases were reviewed** **One (1) case excluded (not in CM)** **Ten (10) cases were compliant.** **COMPLEX CM FILE REVIEW:** **Twelve (12) cases were reviewed** **Two (2) cases excluded (both UTR)** **Ten (10) cases were compliant.**	
6.30.2.11.1.	Behavioral health pharmacy prior authorization decisions are rendered before a member is discharged from a behavioral health facility (including, but not limited to, inpatient psychiatric facilities, PRTF's, and residential substance use disorder settings).	P/P for care coordination		Full	This requirement is addressed in Policy 156.800 Care Transition Discharge Planning, page 3, paragraph 3; and UM.004L PRTF Policy, page 1-7.	
6.30.2.11.2.	Care managers follow-up with members with a behavioral health related diagnosis within 72 hours following discharge.	P/P for care coordination CM records Includes Care Management File Review		Full	This requirement is addressed in Policy 156.800 Care Transition Discharge Planning, page 2, paragraph 3; and UM.004L PRTF Policy, page 4, RROT referral. **BH CM FILE REVIEW:** **Eleven (11) cases were reviewed** **One (1) case excluded (not in CM)** **Ten (10) cases were compliant.** **COMPLEX CM FILE REVIEW:** **Twelve (12) cases were reviewed** **Two (2) cases excluded (both UTR)** **Ten (10) cases were compliant.**	
6.30.2.11.3.	Coordination with LDH and other state agencies following an inpatient, PRTF, or other residential stay for members with a primary behavioral health diagnosis occurs timely when the member is not to return home.	P/P for care coordination		Full	This requirement is addressed in Policy 156.800 Care Transition Discharge Planning, page 3; and UM.004L PRTF Policy, page 4, RROT referral.	
6.30.2.11.4	Members approaching the end of medical necessity/continued stay for PRTF or TGH have concrete and proactive discharge plans in	P/P for care coordination		Full	**This requirement is addressed in 156.800 Care Transition Discharge Planning, page 5; and UM.004L PRTF Policy, page 4 g ii, RROT**	

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	place, including linkage with aftercare providers to address the member's treatment needs in the member's next recommended level of care or living situation. Concrete and proactive discharge plans, including linkage with aftercare providers in the member's next LOC or living situation, should be in place thirty (30) calendar days prior to discharge from a PRTF or TGH. The MCO shall follow up and coordinate with the discharging PRTF or TGH, receiving provider(s), and the member/guardian to ensure that the member is contacted by and is receiving services from aftercare providers as per the member's discharge plan.	Includes Care Management File Review			**referral.** **BH CM FILE REVIEW:** **Eleven (11) cases were reviewed** **One (1) case excluded (not in CM)** **Ten (10) cases were compliant.** **COMPLEX CM FILE REVIEW:** **Twelve (12) cases were reviewed** **Two (2) cases excluded (both UTR)** **Ten (10) cases were compliant.**	
6.30.2.12	Document authorized referrals in its utilization management system;	P/P for care coordination		Full	This requirement is addressed in UM.004L PRTF Policy, page 4, 5 e.	
6.30.2.13	Provide active assistance to members receiving treatment for chronic and acute medical conditions or behavioral health conditions to transition to another provider when their current provider has terminated participation with the MCO. The MCO shall provide continuation of such services for up to ninety (90) calendar days or until the member is reasonably transferred without interruption of care, whichever is less:	P/P for care coordination		Full	This requirement is addressed in 153.706L Continuity of Care, pages 3 and 5, procedure B #1-3 (policy in O8-UM Folder); and Policy 156.801 Care Coordination, page 5, bullet F.	
6.30.2.14	Coordinate with the court system and state child-serving agencies with regard to court- and agency-involved youth, to ensure that appropriate services can be accessed. This may include, but is not limited to, attending court proceedings at the request of LDH when there is a need to inform the court of available services and limitations, and participating in cross-agency staffing; and	P/P care coordination Court proceedings		Full	This requirement is addressed in 156.800 Care Transition Discharge Planning, page 2, paragraph 9, and page 3, paragraph 5; and Policy 156.701 – Coordination with other Healthcare and Non-healthcare Services, pages 5-m and 5-n.	
6.30.2.15	For the behavioral health population, provide aftercare planning for members prior to discharge	P/P care coordination		Full	This requirement is addressed in Policy 156.800 Care Transition Discharge Planning,	

Core Benefits and Services						
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	from a 24-hour facility.				page 3, paragraph 5.	
6.36	**Continuity for Behavioral Health Care**					
6.36.1	The PCP shall provide basic behavioral health services (as described in this Section) and refer the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services.	P/P for BH care continuity Provider contract Provider manual/handbook		Full	This requirement is addressed in 156.900 Continuity for BH Care, page 4; and ACLA Provider Handbook, pages 18, 40, and 51.	
6.36.2	The MCO shall establish policies and procedures to facilitate the integration of physical and behavioral health and to provide for the appropriate continuity of care across programs. Principles that guide care integration are as follows: • Mental illness and addiction are healthcare issues and must be integrated into a comprehensive physical and behavioral healthcare system that includes primary care settings; • Many people suffer from both mental illness and addiction. As care is provided, both illnesses must be understood, identified, and treated as primary conditions; • The system of care will be accessible and comprehensive, and will fully integrate an array of prevention and treatment services for all age groups. It will be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement; • It is important that relevant clinical information is accessible to both the primary care and behavioral health providers consistent with federal and state laws and other applicable standards of medical record confidentiality and the protection of patient privacy.	P/P for BH care continuity		Full	This requirement is addressed in 156.900 Continuity for BH Care, page 1-3, UM Program Description and Evaluation Integrated; 153.706L Continuity of Care (UM Folder - 08); 156.201 CCM Standards of Practice: Policy, page 1, paragraphs 1 and 2, and page 2-3.	
6.36.3	In any instance when the member presents to the	P/P for BH care continuity		Full	This requirement is addressed in 156.900	

Core Benefits and Services						
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	network provider, including calling the MCO's toll-free number listed on the Member's ID card, and a member is in need of emergency behavioral health services, the MCO shall instruct the member to seek help from the nearest emergency medical provider. The MCO shall initiate follow-up with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed.	Communication member			Continuity for BH Care, Emergency Coordination section, page 9; and member handbook, page 7.	
6.36.4	The MCO shall comply with all post stabilization care service requirements found at 42 CFR §422.113.	P/P for BH care continuity		Full	This requirement is addressed in 153.905 Emergency Room Services, page 2-3.	
6.36.5	The MCO shall include documentation in the member's medical record that attempts are made to engage the member's cooperation and permission to coordinate the member's over-all care plan with the member's behavioral health and primary care provider.	P/P for BH care continuity		Full	This requirement is addressed in Policy 156.204 Member Contact by Care Management Program, page 1; 156.900 Continuity for BH Care, MCO Responsibilities, page 5 #12; 156.201-CCM Standards of Practice, pages 7-C and 7-F, pages 14-11 and 14-12, and page 16-21 H.	
6.36.6	The MCO shall provide procedures and criteria for making referrals and coordinating care with behavioral health and primary care providers and agencies that will promote continuity, as well as, cost-effectiveness of care.	P/P for BH care continuity		Full	This requirement is addressed in Policy 156.701 Coordination with Other Services, page 2; 153.706L Continuity of Care, pages 2-3 and 4-8 (08-UM folder).	
6.36.7	These procedures must address members with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services.	P/P for BH care continuity		Full	This requirement is addressed in 156.202 IHCM Referral Trigger Criteria, Procedure section: Procedure pages 2-4; 153.706L Continuity of Care, pages 2 and 3 (UM-08 folder); 156.701 Coordination with Other Services, pages 3-4 and page 6.	
6.36.8	The MCO shall provide or arrange for training of providers and care managers on identification and screening of behavioral health conditions and	P/P for BH care continuity		Full	This requirement is addressed in 156.900 Continuity for BH Care, MCO Responsibilities section, page 5-13, number 7.	

Core Benefits and Services						
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	referral procedures.					
6.36.9 6.36.9.1.1 6.36.9.1.2 6.36.9.1.3 6.36.9.1.4	The MCO shall work with to strongly support the integration of both physical and behavioral health services through: • Enhanced detection and treatment of behavioral health disorders in primary care settings; • Coordination of care for members with both medical and behavioral health disorders, including promotion of care transition between inpatient services and outpatient care for members with co- existing medical-behavioral health disorders; • Assisting members without a diagnosed behavioral health disorder, who would benefit from psychosocial guidance in adapting to a newly diagnosed chronic medical disorder; • Utilization of approved communication and consultation by PCPs with behavioral health providers of co-enrolled members with co-existing medical and behavioral health disorders requiring co- management.	P/P for BH care coordination		Full	This requirement is addressed in 156.900 Continuity for BH Care, PCP Responsibilities, page 4; MCO Responsibilities, page 5; and Procedure: Referral and Coordination Criteria, page 6.	
6.36.9.1.5	Develop capacity for enhanced rates or incentives to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients.	P/P provider contracting Provider contracts		Full	This requirement is addressed in the NW and Development Plan, pages 9-12.	
6.36.9.1.6	Distributing Release of Information forms as per 42 CFR §431.306, and provide training to MCO providers on its use.	Provider portal/handbook Training materials		Full	This requirement is addressed in the ACLA Provider Handbook, page 92.	
6.36.9.1.7	Educating MCO members and providers regarding appropriate utilization of emergency room (ER) services, including referral to community behavioral health specialists for behavioral health emergencies, as appropriate;	Member/provider handbook Educational materials		Full	This requirement is addressed in the ACLA Provider Handbook, page 53; ACLA Behavioral Health Member Handbook, page 21 (Emergency Services).	

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6.36.9.1.8	Identifying those who use emergency department (ED) services to assist in scheduling follow-up care with PCP and/or appropriate contracted behavioral health specialists;	P/P coordination of care		Full	This requirement is addressed in 156.202 IHCM Referral Trigger Criteria, Procedure section, page 2.	
6.36.9.1.9	Ensuring continuity and coordination of care for members who have been screened positive or determined as having need of specialized medical health services or who may require inpatient/outpatient medical health services. These activities must include referral and follow-up for member(s) requiring behavioral health services.	P/P coordination of care		Full	This requirement is addressed in Policy 156.701 Coordination with Other Healthcare and Non-healthcare Services. Entire policy under Procedure addresses the continuity of coordination of care; and Policy 156.900 Continuity for BH Care, Procedure section, page 1 paragraph 1, and page 5, number 7, 14.	
6.36.9.1.10	Documenting authorized referrals in the MCO's clinical management system;	Clinical management system records		Full	This requirement is addressed in Policy 156.201, procedure 2.	
6.36.9.1.11	Developing capacity for enhanced rates or incentives for integrated care by providers;	P/P provider initiatives		Full	This requirement is addressed in yjr Network Development Management Plan 2018 final, pages 9-10, 11-12, and 14-15, Value-Based Care model.	
6.36.9.1.12	Providing or arranging for training of MCO providers and Care Managers on identification and screening of behavioral health conditions and referral procedures;	Training materials Provider handbook		Full	This requirement is addressed in the Behavioral Health Tool Kit, provider handbook.	
6.36.9.1.13	Conducting Case Management rounds at least monthly with the Behavioral Health Case Management team; and	CM rounds minutes/schedule		Full	This requirement is addressed in UM Program Evaluation, pages 21-22; Policy 156.205 Integrated Case Conference, page 1; and Policy 156.900 Continuity for Behavioral Healthcare and Care Coordination with Primary Care and Behavioral Health Providers, page 3, number 17.	
6.36.9.1.14	Participating in regular collaborative meetings at least yearly or as needed, with LDH representatives for the purpose of coordination and communication.	Meeting minutes		Full	This requirement is addressed in UM Program Evaluation, pages 21-22; 156.900 Continuity for Behavioral Healthcare and Care Coordination with Primary Care and Behavioral Health Providers, page 5, number 16; and Collaborative Meeting minutes.	
6.40	**Case Management (CM) Policies and Procedures**					

Core Benefits and Services						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
6.40.0	The MCO shall submit Case Management Program policies and procedures to LDH for approval within thirty (30) days from the date the Contract is signed by the MCO, annually and prior to any revisions. Case Management policies and procedures shall include, at a minimum, the following elements:	P/P for CM		Full	This requirement is addressed in 041 ACLA 2018 A_CCMP Policies & Procedures (Annual Evaluation).	
6.40.1	A process to offer voluntary participation in the Case Management Program to eligible members;	P/P for CM		Full	This requirement is addressed in Policy 156.201 – Complex Care Management Standards of Practice, page 12, Procedure section, page 13; and member handbook, Special Programs and 2018 Integrated Health Care Program Description, page 12.	
6.40.2	Identification criteria, process, and triggers for referral and admission into the Case Management Program;	P/P for CM		Full	This requirement is addressed in Policy 156.202 – IHCM Referral Trigger Criteria, Procedure section, pages 2 – 6.	
6.40.3	Identification criteria, process, and triggers for referral and admission into a Perinatal Case Management Program which should include, but not be limited to, the following: .1 Reproductive aged women with a history of prior poor birth outcomes; and .2 High risk pregnant women.	P/P for CM		Full	This requirement is addressed in Policy 156.202 – IHCM Referral Trigger Criteria, Procedure section, pages 3 and 5.	
6.40.4	The provision of an individual needs assessment and diagnostic assessment; the development of an individual plan of care and treatment plan, as necessary, based on the needs assessment; the establishment of short and long term treatment objectives; the monitoring of outcomes; and a process to ensure that treatment care plans are revised as necessary. These procedures shall be designed to accommodate the specific cultural and linguistic needs of the MCO's members; Procedures must describe collaboration processes with member's treatment providers;	P/P for CM Treatment plan template		Full	This requirement is addressed in Policy 156.201 – Complex Care Management Standards of Practice, Definitions: Assessment, Care Plan, Evaluation, Coordinator, & Case Management sections B, C, and D, page 3 of 28, Treatment Plans, page 7 of 28; member handbook – in other languages, page 5 and last page; BH Member Handbook, Freedom of Choice, page 18.	

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6.40.5	A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment care planning;	P/P for CM		Full	This requirement is addressed in Policy 156.201 – Complex Care Management Standards of Practice, Process of Initial Assessment section, page 6 of 28 **(I)**.	
6.40.6	Procedures and criteria for making referrals to specialists and subspecialists;	P/P for CM		Full	This requirement is addressed in Policy 156.201 – Complex Care Management Standards of Practice section, and page 8 of 28 (G), page 7 of 28 (M), and page 15 number 15.	
6.40.7	Procedures and criteria for maintaining care plans and referral services when the member changes PCPs and behavioral health providers; and	P/P for CM		Full	This requirement is addressed in Policy 156.301 – Care Transition: Plan or Provider Change section, page 1; page 3, bullet 8; Policy 156.201 Standards of Practice, page 9, Care Plan, section F.	
6.40.8	Coordination of Case Management activities for members also receiving services through the MCO's Chronic Care Management Program.	P/P for CM		Full	This requirement is addressed in Policy 156.201 – Complex Care Management Standards of Practice, Complex Care Management Program section.	
6.41	**Case Management Reporting Requirements**					
6.41	The MCO shall submit case management reports monthly to LDH. LDH reserves the right to request additional reports as deemed necessary. LDH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports. The case management reports shall include at a minimum:	Evidence of Communication to LDH P/P CM		Full	This requirement is addressed in 039 Case Management Reports, 4/18 – 2/19.	
6.41.1	Number of members identified with potential special healthcare needs utilizing historical claims data;	CM/Special health Care needs reports		Full	This requirement is addressed in 039 Case Management Reports, 4/18 – 2/19.	
6.41.2	Number of members with potential special healthcare needs identified by the member's PCP and/or behavioral health provider;	CM/Special health Care needs reports		Full	This requirement is addressed in 039 Case Management Reports, 4/18 – 2/19.	
6.41.3	Number of members identified with potential special healthcare needs that self- refer;	CM/Special health Care needs reports		Full	This requirement is addressed in 039 Case Management Reports, 4/18 – 2/19.	
6.41.4	Number of members with potential special healthcare needs identified by the	CM/Special health Care needs reports		Full	This requirement is addressed in 039 Case Management Reports, 4/18 – 2/19.	

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	MCO;					
6.41.5	Number of members in the lock-in program;	CM/Special health Care needs reports		Full	This requirement is addressed in 039 Case Management Reports, 4/18–2/19.	
6.41.6	Number of members identified with special healthcare needs by the PASRR Level II authority;	CM/Special health Care needs reports		Full	This requirement is addressed in 039 Case Management Reports, 4/18–2/19.	
6.41.7	Number of members with assessments completed, and	CM/Special health Care needs reports		Full	This requirement is addressed in 039 Case Management Reports, 4/18–2/19.	
6.41.8	Number of members with assessments resulting in a referral for Case Management.	CM/Special health Care needs reports		Full	This requirement is addressed in 039 Case Management Reports, 4/18–2/19.	
6.42	**Chronic Care Management Program (CCMP)**					
6.42.1	The MCO shall provide a Chronic Care Management Program (CCMP) for members diagnosed with the following chronic conditions: Asthma; Congestive heart failure; Diabetes; HIV; Hepatitis C; Obesity; and Sickle Cell Anemia, particularly diagnosed members who are high utilizers of ED and inpatient services.	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in Policy 156.201: Complex Care Management Standards of Practice, page 1, paragraph 4; 2018 IHCM Program Description, page 5, bullet 6; Policy 156.202 IHCM Referral Trigger Criteria, page 4, bullet 5-14; and ACLA Provider Handbook, page 19, bullet 3.	
6.42.3	The MCO shall also include one of the following chronic conditions in the CCMP for its members: hypertension as a precursor to coronary artery disease and stroke; chronic obstructive pulmonary disease (COPD), low back pain and chronic pain. Additional chronic conditions may be added at the MCO's discretion. The MCO shall include additional discretionary chronic conditions in CCMP reports, as delineated for required chronic conditions in the CCMP, to LDH.	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in 2018 IHCM Program Description, page 3 and Appendices A-I.	
6.42.4	The MCO shall submit Chronic Care Management Program policies and procedures to LDH for approval within thirty (30) days of signing the Contract, annually and previous to any revisions. The MCO shall develop and implement policies and procedures that:	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in 041 ACLA 2018 A_CCMP Policies and Procedures (Annual Evaluation).	
6.42.4.1	Include the definition of the target population;	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in 2018 IHCM Program Description, page 27-29,	

Core Benefits and Services						
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					Appendices A-I, and Policy 156.202 IHCM Referral Trigger Criteria, page 4, paragraph 1.	
6.42.4.2	Include member identification strategies, i.e. through encounter data;	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in 2018 IHCM Program Description, page 8-9, Appendices A-I.	
6.42.4.3	Include evidence-based clinical guidelines that have been formally adopted by the QA/PI committee;	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in 2018 IHCM Program Description, page 17-19, Appendices A-I, and QAPI Committee Meeting minutes Q12018, page 8.	
6.42.4.4	Include guidelines for treatment plan development, as described in NCQA Disease Management program content, that provide the outline for all program activities and interventions;	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in Policy 156.201: Complex Care Management Standards of Practice, page 3, Item B; 2018 IHCM Program Description, page 14, paragraph 1; Appendices A-I.	
6.42.4.5	Include a written description of the stratification levels for each chronic condition, including member criteria and associated interventions;	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in 018 IHCM Program Description, Appendix C; 2018 IHCM Program Evaluation: 4 Quad Model, page 37.	
6.42.4.6	Include methods for informing and educating members and providers;	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in Policy 156.300 Care Transition Discharge Planning, page 3, paragraph 3.	
6.42.4.7	Emphasize exacerbation and complication prevention utilizing evidence- based clinical practice guidelines and patient empowerment and activation strategies;	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in Policy 156.300 Care Management & Care Coordination Blended Model for Disease Management, section: Procedure, pages 3-5; 2018 IHCM Program Evaluation, Clinical Practice Guidelines section, pages 115-116; Krames on Demand – 86311 – Discharge Instructions COPD, last section, When to Call your Health Care Provider.	
6.42.4.8	Address co-morbidities through a whole-person approach;	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in Policy 156.300 Care Management and Care Coordination Blended Model for Disease Management, page 3-5; 2018 IHCM Program Description, page 2, paragraphs 2 and 3.	
6.42.4.9	Identify members who require in-person case management services and a plan to meet this	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in 2018 IHCM Program Description –Integrated Health Care	

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	need;				Management Team section, page 6, paragraph 1, and page 7, rows 2, 3, and 4.	
6.42.4.10	Coordinate CCMP activities for members also identified in the Case Management Program; and	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in Policy 156.300 Care Management and Care Coordination Blended Model for Disease Management, page 4, paragraph 2.	
6.42.4.11	Include Program Evaluation requirements.	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in 2018 IHCM Program Evaluation.	
6.44	**CCMP Reporting Requirements**					
6.44.1	The MCO shall submit Chronic Care Management reports quarterly to LDH. LDH reserves the right to request additional reports as deemed necessary. LDH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports.	Communications to LDH		Full	This requirement is addressed in Change to Making Medicaid Better Report 042 Retirement on 5/16/18 provided by LDH/MCO.	
6.44.2	The CCMP reports shall contain at a minimum:					
6.44.2.1	Total number of members;	CCMC reports		Not applicable	Statement does not require a review. Retirement Letter on 5/16/18 provided by LDH/MCO.	
6.44.2.2	Number of members in each stratification level for each chronic condition; and	CCMC reports		Not applicable	Statement does not require a review. Retirement Letter on 5/16/18 provided by LDH/MCO.	
6.44.2.3	Number of members who were disenrolled from program and explanation as to why they were disenrolled.	CCMC reports		Not applicable	Statement does not require a review. Retirement Letter on 5/16/18 provided by LDH/MCO.	
6.44.3 6.44.3.1	The MCO shall submit the following report annually: Chronic Care Management Program evaluation.	CCMC reports		Not applicable	Statement does not require a review. Retirement Letter on 5/16/18 provided by LDH/MCO.	

Provider Network Requirements

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
7.1	**General Provider Network Requirements**					
7.1.1	The MCO shall maintain and monitor a network of appropriate providers that is supported by written network provider agreements and that is sufficient to provide adequate access to all services covered under this contract for all members, including those with limited English proficiency or physical or mental disabilities.					
7.1.2	The MCO must maintain a network that ensures, at minimum, equal access to qualified providers as the rest of the insured population in the area. [42 CFR 438.210.(a)(2)]	Network Provider Development and Management Plan P/P for Provider Network		Full	This requirement is addressed in the Network Development Plan in section 7.3 Geo Access Requirements of this review.	
7.1.3	All services covered under this contract shall be accessible to MCO members in comparable timeliness, amount, duration and scope as those available to other insured individuals in the same service area.	Network Provider Development and Management Plan P/P for Provider Network P/P for Access and Availability		Full	This requirement is addressed in the Network Development Plan in section 7.3 Geo Access Requirements of this review.	
7.1.4	Network providers must be available within a reasonable distance to members and accessible within an appropriate timeframe to meet the members' medical needs. Standards for distance and time are fully outlined in this Section and in the Provider Network Companion Guide. The MCO shall ensure that providers are available in network within the distance requirements set forth in this Section.	Network Provider Development and Management Plan P/P for Provider Network P/P for Access and Availability		Substantial	This requirement is addressed in the Network Development Plan in section 7.3 Geo Access Requirements of this review. **Recommendations** See recommendations for individual requirements in section 7.3 Geo Access Requirements.	Please see all responses in Section 7.3.

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
7.1.5	If the MCO is unable to provide the necessary services to a member within their network, the MCO must adequately and timely cover these services out of network. The MCO shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR §438.206.(b)(4) and (5)].	Network Provider Development and Management Plan P/P for Provider Network		Full	This requirement is addressed in Authorization for Out-of-Network Practitioners and Providers Policy and Procedure on pages 1 to 2, and Network Development Management Plan 2018 Resubmit on pages 13, 21, 23, and 26.	
7.1.7	The MCO's network providers shall ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid members with physical or mental disabilities.	P/P for Provider Network P/P for Access and Availability		Full	This requirement is addressed in the provider handbook on page 28.	
7.1.8	At the request of the member, the MCO shall provide for a second opinion from a network provider, or arrange for the member to obtain one outside the network, at no cost to the member.	P/P for Provider Network P/P for Access and Availability		Full	This requirement is addressed in the member handbook on pages 15-16.	
7.1.9	The MCO and its providers shall deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity and provide for cultural competency and linguistic needs, including the member's prevalent language(s) and sign language interpreters in accordance with 42 CFR §438.206(c)(2). MCOs must ensure that effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs are provided. Assurances shall be achieved by: • Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual	Network Provider Development and Management Plan P/P for Provider Network Provider manual/handbook Provider contracts		Substantial	This requirement is addressed in the Provider Culture and Ethnicity Policy and Procedure and "FAX BLAST Provider Cultural Competency Training." Missing from the documentation is the requirement in bullet point 1 about collecting member demographic data. **Recommendations** The MCO should collect, and document that they collect, demographic data so that the needs of the community can be met.	ACLA will add this requirement to the Provider Culture and Ethnicity Policy (#CPNM 339.450) to ensure and validate that the collection of this demographic data is occurring in order to meet the needs of the community.

Provider Network Requirements						
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	orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required); • Assessing the cultural competency of the providers on an ongoing basis, at least annually; • Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.; • Assessing provider satisfaction of the services provided by the MCO at least annually; and • Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments.					
7.2						
7.2.1	The following appointment availability standards have been established as minimum requirements to ensure that members' needs are sufficiently met. LDH will monitor the MCO's compliance with these standards through regular reporting as shown in Provider Network Companion Guide. The MCO shall ensure that appointments with qualified providers are on a timely basis, as follows:					
7.2.1.1	Emergent or emergency visits immediately upon presentation at the service delivery site. Emergent, crisis or emergency behavioral health	P/P for Provider Network P/P for Provider Appointment Standards		Full	This requirement is addressed in the member handbook update on page 22.	

Provider Network Requirements						
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	services must be available at all times and an appointment shall be arranged within one (1) hour of request;	ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts ACLA Member Handbook				
7.2.1.2	Urgent Care within twenty-four (24) hours. Provisions must be available for obtaining urgent care, including behavioral health care, 24 hours per day, 7 days per week. Urgent care may be provided directly by the PCP or directed by the MCO through other arrangements. An appointment shall be arranged within forty-eight (48) hours of request;	P/P for Provider Network P/P for Provider Appointment Standards ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts ACLA Member Handbook		Full	This requirement is addressed in the provider handbook on page 22 and Provider Accessibility and Availability Standards and Compliance Policy and Procedure.	
7.2.1.3	Non-urgent sick care within 72 hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition;	P/P for Provider Network P/P for Provider Appointment Standards ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts ACLA Member Handbook		Full	This requirement is addressed in the provider handbook on page 22 and Provider Accessibility and Availability Standards and Compliance Policy and Procedure.	
7.2.1.4	Routine, non-urgent, or preventative care visits within 6 weeks. For behavioral healthcare, routine, non-urgent appointments shall be arranged within fourteen (14) days of referral;	P/P for Provider Network P/P for Provider Appointment Standards ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts ACLA Member Handbook		Full	This requirement is addressed in the provider handbook on page 22 and Provider Accessibility and Availability Standards and Compliance Policy and Procedure.	
7.2.1.5	Specialty care consultation within one (1) month of referral or as clinically indicated;	P/P for Provider Network P/P for Provider Appointment Standards ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts		Full	This requirement is addressed in the provider handbook on page 26 and Provider Accessibility and Availability Standards and Compliance Policy and Procedure.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
		ACLA Member Handbook				
7.2.1.6	Lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and 48 hours for urgent care or as clinically indicated; and	P/P for Provider Network P/P for Provider Appointment Standards ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts ACLA Member Handbook		Full	This requirement is addressed in the provider handbook on page 26 and Provider Accessibility and Availability Standards and Compliance Policy and Procedure.	
7.2.1.7	Maternity Care - Initial appointment for prenatal visits for newly enrolled pregnant women shall meet the following timetables from the postmark date the MCO mails the member's welcome packet for members whose basis of eligibility at the time of enrollment in the MCO is pregnancy. The timeframes below apply for existing members or new members whose basis of eligibility is something other than pregnancy from the date the MCO or their subcontracted provider becomes aware of the pregnancy: within their first trimester within 14 days; within the second trimester within 7 days; within their third trimester within 3 days; high risk pregnancies within 3 days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists;	P/P for Provider Network P/P for Provider Appointment Standards ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts ACLA Member Handbook		Full	This requirement is addressed in the provider handbook on page 26 and Provider Accessibility and Availability Standards and Compliance Policy and Procedure.	
7.2.1.8	Follow-up to ED visits in accordance with ED attending provider discharge instructions.	P/P for Provider Network P/P for Provider Appointment Standards ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts ACLA Member Handbook		Full	This requirement is addressed in Provider Accessibility and Availability Standards and Compliance Policy and Procedure.	
7.2.1.9 7.2.1.10	In office waiting time for scheduled appointments should not routinely exceed 45 minutes, including	P/P for Provider Network P/P for Provider		Full	This requirement is addressed in the provider handbook on page 22, and Provider	ACLA has removed the word "average" from the

Provider Network Requirements						
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7.2.1.11 7.2.1.12	time in the waiting room and examining room. If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than 90 minutes, the patient shall be offered a new appointment. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.	Appointment Standards ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts ACLA Member Handbook			Accessibility and Availability Standards and Compliance Policy and Procedure. **Recommendations** The MCO documentation indicates that wait times will not exceed 45 minutes on average' the contract specifies "should not routinely exceed 45 minutes." The MCO should remove reference to average from documentation.	Provider Handbook.
7.3						
7.3.0	The MCO shall comply with the following maximum travel time and/or distance requirements, as specified in the Provider Network Companion Guide. Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval. Such requests should include data on the local provider population available to the non-Medicaid population. If LDH approves the exception, the MCO shall monitor member access to the specific provider type on an ongoing basis and provide the findings to LDH as part of its annual Network Provider Development Management Plan.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Substantial	This requirement is addressed in the following requirements of section 7.3 Geo Access Requirements. **Recommendations** See recommendations for individual requirements in section 7.3.	Please see all responses below that responsive to this element.
7.3.1 7.3.1.1 7.3.1.2	Primary Care Providers .3 Travel distance for members living in rural parishes shall not exceed 30 miles; and .4 Travel distance for members living in urban parishes shall not exceed 10 miles	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Substantial	This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 3. A review of geo access reports indicates that time or distance requirements are met for all rural parishes, but not for all urban parishes. **Recommendations** The MCO should improve access to PCPs for their urban members.	The requirement as stated in 7.3 and the Provider Network Companion guide is "The MCO shall comply with the following maximum travel time and/or distance requirements, as specified in the Provider Network Companion Guide."

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
						As of 8/12/2019, 99.9% of members in urban areas have access to an Adult or Pediatric PCP within the 20 minute requirement. ACLA is open to adding PCPs as providers' request. ACLA is currently outreaching providers who have been exclusively signed up with one or two health plans to add them to the network.
7.3.2 7.3.2.1 7.3.2.2	Acute Inpatient Hospitals • Travel distance for members living in rural parishes shall not exceed 30 miles; If no hospital is available within 30 miles of a member's residence, the MCO may request, in writing, an exception to this requirement. • Travel distance for members living in urban parishes shall not exceed 10 miles.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Substantial	This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 4. A review of geo access reports indicates that time or distance requirements are met for all rural parishes, but not for all urban parishes. **Recommendations** The MCO should improve access to acute inpatient hospitals for their urban members.	The requirement as stated in 7.3 and the Provider Network Companion guide is "The MCO shall comply with the following maximum travel time and/or distance requirements, as specified in the Provider Network Companion Guide." As of 8/12/2019, 99.1% of the members in urban parishes have access to an acute hospital within the 20 minute requirement. ACLA is contracted with all acute inpatient hospitals at this time. See the attached PH Network Development Service document in the row above.

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
7.3.3 7.3.3.1 7.3.3.2 7.3.3.3 7.3.3.4	Specialists • Travel distance to each specialty type shall not exceed 60 miles for at least 75% of members; and • Travel distance shall not exceed 90 miles for all members. • Specialists included under this requirement are listed the Provider Network Companion Guide.. LDH reserves the right to add additional specialty types as needed to meet the medical needs of the member population. • Telemedicine may be used to facilitate access to specialists to augment MCO's network or to meet specific needs of a subset of the MCO's membership. If an MCO intends to utilize telemedicine to meet network adequacy requirements, the MCO's telemedicine utilization must be approved by LDH for this purpose.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Substantial	This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 5. A review of geo access reports indicates that time or distance requirements are not met for all parishes in most specialties. **Recommendations** The MCO should improve member access for most specialties.	Specialty types with gaps include Allergy/Immunology, Dermatology, Endocrinology, Hematology, and Nephrology. Two (2) parishes in Region 7 have gaps for 3 of these specialty types and four parishes in Region 5 have gaps for Endocrinology. Region 6 has the largest gap for four of the specialty types noted above with the exception of Nephrology. Region 8 has gaps for the four specialty types noted above. ACLA is currently outreaching providers who historically only contracted with one or 2 of the MCO(s) to add them to the network which will add PCPs and specialty providers.
7.3.4 7.3.4.1 7.3.4.2	Lab and Radiology Services • Travel distance shall not exceed 20 miles in urban parishes; and • Travel distance shall not exceed 30 miles for rural parishes.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Substantial	This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 4. A review of geo access reports indicates that time or distance requirements were met for all rural parishes, but not for all urban parishes. **Recommendations** The MCO should improve member access to lab and radiology services in urban parishes.	There are multiple hospitals, urgent care centers, and physician offices that provide lab services which are not included in this geo-access mapping. ACLA is also contracted with three large lab companies that work directly with physicians by arranging pick up of testing or lab draws at the physician offices which

Provider Network Requirements						
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					The MCO has indicated that the Geo Access Report only includes stand-alone lab and radiology services and that more lab and radiology services are provided to members that are not counted in the geo access report.	increases access and compliance for enrollees who are unable or unwilling to drive to a specific lab for lab draws/testing.
7.3.5 7.3.5.1 7.3.5.2	Pharmacies .3 Travel distance shall not exceed 10 miles in urban parishes; and .4 Travel distance shall not exceed 30 miles in rural parishes.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Substantial	This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 4. A review of geo access reports indicates that time or distance requirements were met for all rural parishes, but not for all urban parishes. **Recommendations** The MCO should improve member access to pharmacies in urban parishes.	ACLA is currently contracted with 1,182 pharmacy locations in Louisiana. Per NCPDP, there are currently nine pharmacies in the parishes with gaps (three in Plaquemines and six in Union). ACLA is contracted with all nine. ACLA is contracted with 71 pharmacies in Region 5 and 213 in Region 1. Only 0.1% of the enrollees in urban parishes do not have access within 20 minutes. Enrollees in all urban parishes, with the exception of Cameron and Plaquemines, have a drive time within 20 minutes to a pharmacy. AmeriHealth Caritas' PerformRx is our pharmacy benefit manager who builds our network to meet members' access needs and provides access to retail and specialty pharmacy providers.

Provider Network Requirements						
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7.3.6 7.3.6.1 7.3.6.2	Hemodialysis Centers .3 Travel distance shall not exceed 10 miles in urban areas; and .4 Travel distance shall not exceed 30 miles in rural areas.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Minimal	This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 4. A review of geo access reports indicates that time or distance requirements were met for some rural parishes and most urban parishes. **Recommendations** The MCO should improve member access to hemodialysis centers in rural parishes and especially in urban parishes.	Only 1.8% of the enrollees in urban parishes drive more than 20 minutes to this provider type. Among nine urban parishes in Regions 1, 2, 3, 5, 6, and 7, more than 90% of the enrollees have access within the required driving time. These include Bossier, Caddo, Calcasieu, De Soto, Pointe Coupee, Rapides, St. Bernard, Terrebonne and West Feliciana. The largest percentage of enrollees who drive more than the maximum standard reside in Cameron (Region 5), Grant (Region 6), Lafourche (Region 3), Plaquemines (Region 1), and Union (Region 8) parishes. ACLA is working with providers to expand this level of care. There are 178 providers to date. Two new centers were added to ACLA's network in Quarter 2 2019 in Regions 1 and 6. ACLA continues to work with large providers, i.e. Fresenius, to increase access to these centers. See document above.

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
7.3.7 7.3.7.1	**Specialized Behavioral Health Providers** Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN Nurse Practitioner or Clinical Nurse Specialist (CNS) in mental health, or LCSW's) and to psychiatrists for members living in rural parishes shall not exceed 30 miles or 60 minutes for 90% of such members.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Full	A review of geo access reports indicates that time or distance requirements were met for rural parishes.	
7.3.7.2	Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN Nurse Practitioner or CNS in mental health, or LCSW's) and to psychiatrists for members living in urban parishes shall not exceed 15 miles or 30 minutes for 90% of such members.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Substantial	A review of geo access reports indicates that time or distance requirements were not met for urban parishes. **Recommendations** The MCO should improve member access to specialized behavioral health providers in urban parishes.	One hundred percent (100%) of enrollees in rural parishes have access to a BHS within 60 minutes, whereas 99.8% of enrollees in urban parishes have access within the standard of 30 minutes. In Plaquemines Parish, 35% of the enrollees need to travel slightly more than the 30 minute standard. ACLA welcomes individual SBHS providers into the network and works with these providers to retain them.
7.3.7.3	Travel distance to psychiatric inpatient hospital services shall not exceed 90 miles or 90 minutes for 90% of members. Maximum time for admission shall not exceed 4 hours (emergency involuntary), 24 hours (involuntary), or 24 hours (voluntary).	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Full	This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 6. Policy meets standards, but does not include the 90% of members. This requirement is met by BH GEO Access & Network Gap analysis Q4 2018 (sample). A review of geo access reports indicates that time or distance requirements were met for	One hundred percent (100%) of members in urban and rural parishes have access to an inpatient psychiatric hospital within the required standard. See above report in previous row.

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					urban and rural parishes. Missing from the documentation provided are admissions data. **Recommendations** The MCO should record and report admissions time for psychiatric inpatient hospital services. **Final Review Determination** Review determination changed to full. LDH has confirmed that MCOs were not required to report admission or appointment times.	
7.3.7.4	Travel distance to ASAM Level 3.3 shall not exceed 30 miles or 60 minutes for 90% of adult members. Maximum time for admission or appointment shall not exceed 10 business days.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Substantial	This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 6. A review of geo access reports indicates that time or distance requirements were not met for urban or rural parishes. Missing from the documentation provided are admissions data. **Recommendations** The MCO should improve member access to ASAM level 3.3. The MCO should record and report admission or appointment times for ASAM level 3.3 **Final Review Determination** Review determination changed to substantial. While time and distance	Statutory report 359, Measurement 2 addressed the minimum performance thresholds for time of admission or appointment but this was never required and discontinued July 2018. ACLA continues to encourage these provider types to enter the ACLA network. ACLA has reached an agreement with Acadia Healthcare for ASAM Residential for adults and adolescents. ACLA completed contracting and credentialing for a new entity Substance Use Residential program and for existing sites with Addiction Recovery

Provider Network Requirements						
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					standards are not met LDH has confirmed that MCOs were not required to report admission or appointment times.	Resources which involved a change of ownership for 3 sites in Metairie and one site in Destrehan, La. These are referenced as Avenues Recovery. ACLA is also working on contracting with a Substance Residential Provider who has historically only accepted commercial pay in the New Orleans area. ACLA completed a project involving outreach to all network Substance Use providers to verify ASAM levels as these provider types added capacity and/or locations without notifying ACLA. Work requests to add or change ASAM levels is in progress. One provider in Ruston became credentialed adding SU Residential services. ACLA is contracted with all Opioid Treatment Program providers with the exception of Choices who has not yet submitted a packet. See BH report above.
7.3.7.5	Travel distance to ASAM Level 3.5 shall not exceed 30 miles or 60 minutes for 90% of adult members	Network Provider Development and		Substantial	This requirement is addressed in Provider Availability Standards Analysis Policy and	Same feedback as above.

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	and shall not exceed 60 miles or 90 minutes for adolescent members. Maximum time for admission or appointment shall not exceed 10 business days.	Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions			Procedure on page 6. A review of geo access reports indicates that time or distance requirements were not met for urban or rural parishes. Missing from the documentation provided are admissions data. **Recommendations** The MCO should improve member access to ASAM level 3.5. The MCO should also record and report admission or appointment times for ASAM level 3.5. **Final Review Determination** Review determination changed to substantial. While time and distance standards are not met LDH has confirmed that MCOs were not required to report admission or appointment times.	
7.3.7.6	Travel distance to ASAM Level 3.7 co-occurring treatment shall not exceed 60 miles or 90 minutes for 90% of adult members. Maximus time for admission or appointment shall not exceed 10 business days.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Substantial	This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 6. A review of geo access reports indicates that time or distance requirements were not met for urban or rural parishes. Missing from the documentation provided are admissions data. **Recommendations** The MCO should improve member access to ASAM level 3.7 co-occurring treatment.	Same as above.

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					The MCO should record and report admission or appointment times for ASAM level 3.7 co-occurring treatment. **Final Review Determination** Review determination changed to substantial. While time and distance standards are not met LDH has confirmed that MCOs were not required to report admission or appointment times.	
7.3.7.7	Travel distance to ASAM Level 3.7WM shall not exceed 60 miles or 90 minutes for 90% of adult members. Maximum time for admission or appointment shall not exceed 10 business days. Withdrawal management shall be available within 24 hours when medically necessary.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Full	This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 6. A review of geo access reports indicates that time or distance requirements were met for urban or rural parishes. Missing from the documentation provided are admissions data. **<u>Recommendations</u>** The MCO should record and report admission or appointment times for ASAM level 3.5WM. **Final Review Determination** Review determination changed to full. LDH has confirmed that MCOs were not required to report admission or appointment times.	Same as above.
7.3.7.8	Travel distance to Psychiatric Residential Treatment Facilities (PRTF) shall not exceed 200 miles or 3.5 hours for 100% of members. Maximum time for admission shall not exceed 20	Network Provider Development and Management Plan P/P for Access and		Full	This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 6.	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	calendar days. Access and adequacy is based on availability of in-state PRTFs unless the MCO provides evidence that indicates an out-of-state provider is clinically appropriate to treat the specific needs of the member.	Availability GeoAccess reports Requests for exceptions			This requirement is met by BH GEO Access & Network Gap Analysis Q4 2018 (sample).	
7.3.7.9	Request for exceptions as a result of prevailing community standards for time and distance accessibility standards must be submitted in writing to LDH for approval.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Full	This requirement is addressed in Network Development Management Plan 2018 Resubmit on pages 11 to 12.	
7.3.7.10	There shall be no penalty if the member chooses to travel further than established access standards in order to access a preferred provider. The member shall be responsible for travel arrangements and costs.	P/P Access standards ACLA Member Handbook		Full	This requirement is addressed in Provider Availability Standards Analysis Policy and Procedure on page 3.	
7.4.1	**Provider to Member Ratios** The MCO must demonstrate that their network has a sufficient number of providers and facilities to meet minimum ratio requirements and allow adequate access for members. Adequate ratios of providers to members can be found in the Provider Network Companion Guide.	Network Provider Development and Management Plan P/P for Access and Availability Evidence of meeting provider to member ratios		Full	This requirement is addressed in the Network Development Management Plan on pages 12 to 13 and in the Availability of Practitioners Annual Report.	
7.5						
7.5.1 7.5.1.1 7.5.1.2	Appointment Availability Monitoring • The MCO shall have written policies and procedures about educating its provider network about appointment time requirements. The MCO must include their appointment standards in the Provider Manual and shall disseminate appointment standards and procedures to its members and include this information on their website. The MCO is encouraged to include the standards in the provider subcontracts.	Network Provider Development and Management Plan Provider contracts Provider manual/handbook P/P for Access and Availability P/P for Monitoring Provider Compliance with Access Standards Plan website		Full	This requirement is addressed in the Provider Handbook on pages 22 and 25, and Policy 159.201	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	• The MCO is responsible for monitoring and assurance of provider compliance with appointment availability standards and provision of appropriate after-hour coverage.	Evidence that monitoring was implemented				
7.5.2 7.5.2.1 7.5.2.2 7.5.2.3	**Geographic Availability Monitoring** The MCO shall submit quarterly GeoAccess reports documenting the geographic availability of network providers including PCPs, hospitals, pharmacies, and each specialty type listed the Provider Network Companion Guide. The attestation included with this report shall provide narrative identifying any gaps in coverage and the corrective measures that will address them. The data in the quarterly GeoAccess reports shall be current, accurate, and consistent with provider registry data submitted to LDH by the plans as required in the **MCO Systems Companion Guide.** The MCO report on accessibility shall include assessment of coverage including distance, population density, and provider availability variables. All gaps in coverage must be identified and addressed in the Network Development Plan.	GeoAccess reports Communication to LDH/ attestation		Full	This requirement was addressed in BH Geo Access & Network Gap Analysis Q4 Report. Missing from the reports were the following specialty types found in the Provider Network Companion Guide: Dental pediatric, psychiatric residential treatment facilities ([PRTFs] pediatric), substance use residential treatment facilities - adult population, substance use residential treatment facilities - adolescent population, and psychiatric inpatient hospital services. **Recommendations** The MCO should include the identified specialties in the Annual Geo Access Reports. **Final Review Determination:** Review determination changed to full. The specialties located in the network companion guide are found in the geoaccess report.	Geographic Availability for PRTF and Substance Use Residential treatment facilities is addressed in the 349 Unmet Service Needs 2018 (pages 7-9) and the Network Developmental Management Plan 2018 and the ACLA BH GeoAccess – Time and Distance reports. The ACLA BH GeoAccess – Time and Distance reports indicate that 100% of the members in both rural and urban have access with the required time standard. The BH GeoAccess report is embedded above.
7.5.3 7.5.3.1 7.5.3.2	**Provider to Member Ratios** • Quarterly GeoAccess reports shall include analysis of provider-to-member ratios in each geographical area as outlined in this Section	GeoAccess reports Communications to LDH		Minimal	This requirement is addressed in the 348 BH and 220 PH Geo Access Reports. Missing from the reports are provider-to-member ratios.	The Provider Network Companion Guide has the provider-to-member ratios for 12 specialty types, i.e.

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	and the Provider Network Companion Guide. • Member linkages to Primary Care providers shall be submitted to LDH weekly as described in the MCO Systems Companion Guide.				**Recommendations** The MCO should include provider-to-member ratios in the Geo Access Reports. **Final Review Determination:** No change in determination. We cannot accept new documents at this stage and the attached document is outside the review period (April 1, 2018 – March 31, 2019).	Allergy/Immunology is 1:100,000. The BH and PH GeoAccess reports include the number of members located in each parish. The number of providers for each provider type is noted on the actual maps. The total number of members divided by the number of that specialty type provides the ratio. The ratios have been analyzed on an annual basis. Based on current reporting templates developed by LDH, the provider-to-member ratio is required quarterly for each parish and this was analyzed in Quarter 2 of 2019.
7.6		**Provider Enrollment**				
7.6.1	**Provider Participation -**	Provider contracts Network Provider Development and Management Plan P/P for Provider Network				
7.6.1.6	The MCO must offer a Contract to the following providers: • Louisiana Office of Public Health (OPH); • all OPH-certified School Based Health Clinics (SBHCs); • all small rural hospitals meeting the definition in the Rural Hospital Preservation Act of 1997; • Federally Qualified Health Centers (FQHCs);	Network Provider Development and Management Plan P/P for Provider Network		Full	This requirement is addressed in Practitioner Contracts Policy, and Network Development Management Plan.	

Provider Network Requirements						
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	• Rural Health Clinics (RHCs) (free-standing and hospital based); • Clinics and outpatient providers funded under the HRSA administered Ryan White HIV/AIDS Program. • The MCO shall make a reasonable effort to contract with all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act services; and • All providers approved by the LDH PSH program to provide tenancy and pre-tenancy supports for the Louisiana Permanent Supportive Housing program. • Local Governing Entities; • Methadone Clinics pending CMS approval; • Providers of addiction services for youth and adults at all levels of care (i.e., ASAM Levels 1, 2.1, 2-WM, 3.1, 3.2-WM, 3.3, 3.5, 3.7, 3.7-WM, 4-WM); • Providers of Evidenced Based Practices (EBPs), i.e. Assertive Community Treatment (ACT), Multi-Systemic Therapy (MST), Functional Family Therapy (FFT) and Homebuilders®; • Providers trained to implement specialized behavioral health services for the at-risk youth population age zero (0) – age six (6) [e.g. Parent Child Interaction Therapy (PCIT), Child-Parent Psychotherapy (CPP) and Parent Management Training (PMT)]; • All current Psychiatric Residential Treatment Facilities (PRTFs) and Therapeutic Group Homes (TGHs); • Current LMHPs (Psychologists, LCSW, LPC, LMFT, LAC, APRNs).					

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
7.6.1.7	The MCO shall make a good faith effort to execute a contract with significant traditional providers (STPs). In the event an agreement cannot be reached and a STP does not participate in the MCO, the MCO shall maintain documentation detailing efforts that were made.	Network Provider Development and Management Plan P/P for Provider Network		Full	This requirement is addressed in Practitioner Contracts Policy and Network Development Management Plan on page 27.	
7.6.1.8	If a current Medicaid provider requests participation in an MCO, the MCO shall make a good faith effort to execute a contract. In the event an agreement cannot be reached and the provider does not participate in the MCO, the MCO has met this requirement; the MCO shall maintain documentation detailing efforts made.	Network Provider Development and Management Plan P/P for Provider Network		Full	This requirement is addressed in Practitioner Contracts Policy and Network Development Management Plan.	
7.6.1.9	The provisions above do not prohibit the MCO from limiting provider participation to the extent necessary to meet the needs of the MCO's members. These provisions also do not interfere with measures established by the MCO to control costs and quality consistent with its responsibilities under this contract nor does it preclude the MCO from using reimbursement amounts that are the greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty [42 CFR 438.12(b)(1)].	Network Provider Development and Management Plan P/P for Provider Network		Full	This requirement is addressed in Practitioner Contracts Policy on page 3.	
7.6.1.10	If the MCO declines requests of individuals or groups of providers to be included in the MCO network, the MCO must give the requested providers written notice of the reason for its decision within fourteen (14) calendar days of its decision [42 CFR 438.12(a)(1)].	Network Provider Development and Management Plan P/P for Provider Network P/P for Provider Selection and Retention Evidence of timely notice of denied provider requests for participation Sample notice to providers		Full	This requirement is addressed in Practitioner Contracts Policy on page 3.	
7.6.1.11	The MCO shall work with LDH and other MCOs to	P/P care coordination		Full	This requirement is addressed in Network	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	convene local/regional forums to explore care coordination and care integration and build partnerships with providers.	Meeting/Forum Meetings			Development Management Plan 2018 Resubmit on page 16.	
7.6.1.12	The MCO shall comply with any additional requirements established by LDH.					
7.6.2 7.6.2.1	Exclusion from Participation - The MCO shall not execute contracts with individuals or groups of providers who have been excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)] or state funded health care programs. The list of providers excluded from federally funded health care programs can be found at http://exclusions.oig.hhs.gov/ and the System for Award Management, https://www.sam.gov/index.html/, and Health Integrity and Protection Data Bank at http://www.npdb-hipdb. hrsa.gov/index.jsp.	Network Provider Development and Management Plan P/P for Provider Network P/P for Provider Credentialing P/P for Provider Selection and Retention		Full	This requirement is addressed in Practitioner Contracts Policy on page 9 and Network Development Management Plan on page 28.	
7.6.2.2 7.6.2.2.1 7.6.2.2.2 7.6.2.2.3 7.6.2.2.4 7.6.2.2.5 7.6.2.2.6	The MCO shall not contract or shall terminate contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 (42 U.S.C. §1320a-7) or Section 1156 (42 U.S.C. §1320c-5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. This includes providers undergoing any of the following conditions identified through LDH proceedings: .1 Revocation of the provider's home and community-based services license or behavioral health service license; .2 Exclusion from the Medicaid program; .3 Termination from the Medicaid program; .4 Withholding of Medicaid reimbursement as authorized by the Department's Surveillance	P/P for Provider Network		Full	This requirement is addressed in Practitioner Contracts Policy on page 9 and Network Development Management Plan on page 28.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	and utilization Review (SURS) Rule (LAC 50:I.Chapter 41); .5 Provider fails to timely renew its home and community-based services license as required by the Home and Community-Based Services providers Licensing Standards Rule (LAC 48:I.Chapter 50); or .6 The Louisiana Attorney General's Office has seized the assets of the service provider.					
7.6.2.3	The MCO shall not remit payment for services provided under this contract to providers located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and any U.S. territories.	P/P for Provider Network		Full	This requirement is addressed in Practitioner Contracts Policy on page 7.	
7.6.3 7.6.3.1	Other Enrollment and Disenrollment Requirements - The MCO shall not discriminate with respect to participation in the MCO program, reimbursement or indemnification against any provider solely on the provider's type of licensure or certification [42 CFR 438.12(a)(1)] The MCO shall establish and follow a documented process for credentialing and re-credentialing of network providers [42 CFR §438.12(a)(2). In addition, the MCO must not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)].	Network Provider Development and Management Plan P/P for Provider Network P/P for Provider Selection and Retention P/P for Provider Credentialing		Full	This requirement is addressed in Credentialing/Recredentialing of Practitioners Policy and Procedure on page 3, and Credentialing/Recredentialing Provider Denial, Termination or Reconsideration Appeal Process Policy and Procedure.	
7.6.3.2	All providers shall be in compliance with American with Disabilities Act (ADA) requirements and provide physical access for Medicaid members with disabilities.	Network Provider Development and Management Plan P/P for Provider Network Provider manual/handbook P/P for Provider Credentialing		Full	This requirement is addressed in provider handbook January 2019 update on page 23 and Practitioner Contracts Policy on page 9.	
7.6.3.4	If the MCO terminates a provider's contract for	P/P for Provider Network		Full	This requirement is addressed in Network	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	cause, the MCO shall provide immediate written notice to the provider within one (1) business day of the decision being made. The notice shall be through electronic means followed by a certified letter mailed within one (1) business day. The MCO shall notify LDH through email prior to provider notification.	P/P for Provider Termination Sample notice to providers Sample notice to LDH			Adequacy Policy and Procedure on page 4.	
7.6.3.5	If termination affects network adequacy, the MCO shall include in the notification to LDH their plans to notify MCO members of such change and strategy to ensure timely access for MCO members through different in-network and/or out-of network providers. If termination is related to the MCO's operations, the notification shall include the MCO's plan for how it will ensure there will be no stoppage or interruption of services to members.	P/P for Provider Network P/P for Provider Termination Sample notice to members		Full	This requirement is addressed in the PCP Reassignment Member Letter and Network Adequacy Policy and Procedure on page 6.	
7.6.3.6	The MCO shall make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt of issuance of the termination notice, to each MCO member who received his or her care from or was seen on a regular basis by the terminated provider as specified in 42 CFR §438.10(f)(1) within the past two years.	P/P for Provider Network P/P for Provider Termination Sample notice to members ACLA Member Handbook		Full	This requirement is addressed in the Network Development Management Plan on page 31 and Notice to Members of Provider Termination Policy on page 2.	
7.7						
7.7.1	LDH considers mainstreaming of MCO members into the broader health delivery system to be important. The MCO therefore must ensure that all MCO providers accept members for treatment and that MCO providers do not intentionally segregate members in any way from other persons receiving services.	Provider contracts/Manual		Full	This requirement is addressed in the provider handbook on page 25, and in the Provider Accessibility and Availability Standards and Compliance Policy and Procedure on page 7.	
7.7.2	To ensure mainstreaming of members, the MCO shall take affirmative action so that members are provided covered services without regard to race,	Provider contracts/Manual Member Handbook		Full	This requirement is addressed in the provider handbook on page 25, and in the Provider Accessibility and Availability	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical, behavioral, or cognitive disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:				Standards and Compliance Policy and Procedure on page 8.	
7.7.2.1	Denying or not providing to a member any covered service or availability of a facility.	Provider contracts/Manual		Full	This requirement is addressed in the provider handbook on page 25, and in the Provider Accessibility and Availability Standards and Compliance Policy and Procedure on page 8.	
7.7.2.2	Providing to a member any covered service which is different, or is provided in a different manner, or at a different time from that provided to other members, other public or private patients, or the public at large.	Provider contracts/Manual		Full	This requirement is addressed in the provider handbook on page 25, and in the Provider Accessibility and Availability Standards and Compliance Policy and Procedure on page 8.	
7.7.2.3	Discriminatory practices with regard to members such as separate waiting rooms, separate appointment days, or preference to private pay or Medicaid fee-for-service patients.	Provider contracts/Manual		Full	This requirement is addressed in the provider handbook on page 25, and in the Provider Accessibility and Availability Standards and Compliance Policy and Procedure on page 8.	
7.7.3	When the MCO becomes aware of a specialized behavioral health provider's failure to comply with mainstreaming, the MCO shall develop a written plan for coming into compliance with the Contract requirement for mainstreaming with the behavioral health provider within thirty (30) calendar days and notify LDH in writing	Provider contracts/Manual		Full	This requirement is addressed in the provider handbook on page 25, and in the Provider Accessibility and Availability Standards and Compliance Policy and Procedure on page 8.	
7.7.4	The MCO shall ensure that providers do not exclude treatment or placement of members for authorized behavioral health services solely on the basis of state agency (DCFS or OJJ, etc.) involvement or referral.	Provider contracts/Manual		Substantial	This requirement is addressed in the ACLA Specialty Care Provider Agreement on page 15. Missing from the documentation provided is explicit mention that the MCO shall ensure that providers do not exclude treatment for behavioral health services solely on the basis of state agency	ACLA is adding the statement that "ACLA shall ensure that providers do not exclude treatment or placement of members for authorized behavioral health services solely on

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					involvement. **Recommendations** The MCO should include in the policy the requirement that the MCO shall ensure that providers do not exclude treatment or placement of members for authorized behavioral health services solely on the basis of state agency (DCFS or OJJ, etc.) involvement or referral.	the basis of state agency (DCFS or OJJ, etc.) involvement or referral" to the Provider Manual.
7.8.2	**Primary Care Provider Responsibilities**					
7.8.2.0	The MCO must ensure that network Primary Care Providers fulfill their responsibilities including but not limited to the following:					
7.8.2.1	Managing and coordinating the medical and behavioral health care needs of members to assure that all medically necessary services are made available in a timely manner;	P/P for PCP Responsibilities Provider contracts/Manual		Full	This requirement is addressed in the provider handbook on pages 18 to 20 and the Practitioner Contracts Policy and Procedure on page 8.	
7.8.2.2	Referring patients to subspecialists and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available;	P/P for PCP Responsibilities Provider contracts/Manual		Full	This requirement is addressed in the Practitioner Contracts Policy and Procedure, and the provider handbook, and during the on-site visit, it was explained that ensuring requirements in 7.8.2 is the responsibility of the care management team.	
7.8.2.3	Communicating with other levels of medical care to coordinate, and follow up the care of individual patients;	P/P for PCP responsibilities Provider contracts/Manual		Full	This requirement is addressed in the Practitioner Contracts Policy and Procedure and the provider handbook, and during the on-site visit, it was explained that ensuring requirements in 7.8.2 is the responsibility of the care management team.	
7.8.2.4	Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services available through fee-for-service Medicaid;	P/P for PCP responsibilities Provider contracts/Manual		Full	This requirement is addressed in the Practitioner Contracts Policy and Procedure and the provider handbook, and during the on-site visit, it was explained that ensuring requirements in 7.8.2 is the responsibility of the care management team.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
7.8.2.5	Maintaining a medical record of all services rendered by the PCP and record of referral to other providers and any documentation provided by the rendering provider to the PCP for follow up and/or coordination of care;	P/P for PCP Responsibilities Provider contracts/Manual		Full	This requirement is addressed in the provider handbook on page 18 and in the Practitioner Contracts Policy and Procedures.	
7.8.2.6	Development of plan of care to address risks and medical needs and other responsibilities as defined in Section 6.33.	P/P for PCP Responsibilities Provider contracts/Manual		Full	This requirement is addressed in the Provider Handbook January 2019 Update on page 17.	
7.8.2.7	Ensuring that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information and all state statutes.	P/P for PCP Responsibilities Provider contracts/Manual		Full	This requirement is addressed in the Provider Handbook January 2019 Update on page 17.	
7.8.2.8	Providing after-hours availability to patients who need medical advice. At minimum, PCP office must have a return call system staffed and monitored in order to assure that the member is connected to a designated medical practitioner within 30 minutes of the call.	P/P for PCP Responsibilities Provider contracts/Manual		Full	This requirement is addressed in the provider handbook on page 22.	
7.8.2.9	Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at an MCO participating hospital.	P/P for PCP Responsibilities Provider contracts/Manual		Full	This requirement is addressed in the provider handbook on page 106.	
7.8.2.10	Working with MCO case managers to develop plans of care for members receiving case management services.	P/P for PCP Responsibilities Provider contracts/Manual		Full	This requirement is addressed in the provider handbook on page 18.	
7.8.2.11	Participating in the MCO's case management team, as applicable and medically necessary.	P/P for PCP Responsibilities Provider contracts/Manual		Full	This requirement is addressed in the provider handbook on page 18.	
7.8.2.12	Conducting screens for common behavioral issues, including but not limited to depression, anxiety, trauma/adverse childhood experiences (ACEs), and substance use, to determine whether the member needs behavioral health services.	P/P for PCP Responsibilities Provider contracts/Manual		Full	This requirement is addressed in the MCO website. Common behavioral screen tools are made available to providers.	
7.8.3 7.8.3.1	**Specialty Providers** The MCO shall assure access to specialty					

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	providers, as appropriate, for all members. The MCO shall assure access standards and guidelines to specialty providers are met as specified in this Section in regard to timeliness and service area.					
7.8.3.2	The MCO provider network shall include participating specialists with pediatric expertise for children/adolescents when the need for pediatric specialty care is significantly different from the need for adult specialty care (*e.g.* a pediatric cardiologist).	P/P for Provider Network P/P for Access to Specialty Providers GeoAccess reports		Full	This requirement is addressed in PH Geo Access 2018 Q4 Report.	
7.8.3.3	The MCO shall ensure access to appropriate service settings for members needing medically high risk perinatal care, including both prenatal and neonatal care.	P/P for Provider Network P/P for Access to Specialty Providers GeoAccess reports		Full	This requirement is addressed in the Availability of Practitioners Reporting Period: 2018 Annual Report. **Recommendations** The MCO should ensure access to high-risk prenatal care. Provided documentation only indicates high-risk neonatal care. **Final Review Determination:** Review determination changed to Full. The MCO indicates that they ensure access to high risk perinatal care is addressed.	The ACLA PH GeoAccess by Time report indicates that 99.8% of the female members in urban parishes and 100% in rural parishes have access to an OB/GYN who provides prenatal care. ACLA has a specialized care management program, Bright Start, who works with members during their pregnancy to ensure pregnant members are linked to the appropriate specialty types and services. The 2018 Availability of Practitioners - Network Accessibility report includes OB/GYN for both the High Impact and High Volume Specialty types. The High Impact specialist types are chosen based on the

Provider Network Requirements						
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						requirement of significant resources or due to treatment conditions that have a high mortality or morbidity rate and High Volume defines specialty types with the highest number of visits. These are monitored quarterly and annually. For 2018, the OB/GYN to member ratio was 1:48. In addition, ACLA monitors Maternal Fetal Medicine specialists. This provider type is analyzed and reported in the 2018 Availability of Practitioners report as ACLA chose this Specialty Type as a High Impact Specialist (pages 2, 4, 6). ACLA uses the same time and distance requirements as the Specialty types listed in the Provider Companion Guide and found that 100% of the members met the driving time of 90 minutes for 100% and 100% met the driving distance of 60 miles.
7.8.3.4	The MCO shall establish and maintain a provider network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members (adults and children)	P/P for Provider Network P/P for Access to Specialty Providers GeoAccess reports Evidence of signed		Substantial	This requirement is addressed in section 7.3, Geographic Access Requirements.	See above response.

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	without excessive travel requirements. This means that, at a minimum: • The MCO has signed a contract with providers of the specialty types listed in the Provider Network Companion Guide who accept new members and are available on at least a referral basis; and • The MCO is in compliance with access and availability requirements	contracts with listed specialty provider types				
7.8.3.5	The MCO shall assure, at a minimum, the availability of the specialists listed in the Provider Network Companion Guide with the ratio, distance, and appointment time requirements set in this Section and in the Provider Network Companion Guide.					
7.8.3.6	The MCO will be required to provide a higher ratio of specialists per member population and/or additional specialist types/member ratios may be established, if it is determined by LDH the MCO does not meet the access standards specified in the Contract.	P/P for Provider Network P/P for Access to Specialty Providers		Not applicable	LDH has not required a change to ratio requirements.	
7.8.3.7	In accordance with 42 CFR §438.208(c)(4), for enrollees determined to need a course of treatment or regular monitoring, the MCO must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs.	P/P for Provider Network P/P for Access to Specialty Providers P/P for direct access services		Full	This requirement is addressed in the Provider Availability Standards Analysis Policy and Procedure on page 2 and in the member handbook on page 32.	
7.8.4 7.8.4.1	**Hospitals** Hospital services providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in this RFP.					
7.8.4.2 7.8.4.2.1	The MCO shall include, at a minimum, access to the following:	P/P for Provider Network GeoAccess reports		Full	This requirement is addressed in the Provider Availability Standards Analysis	

Provider Network Requirements						
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7.8.4.2.2	.1 One (1) hospital that provides emergency room services, inpatient, and outpatient care in each parish in the state, provided the parish has such a hospital. .2 MCO must establish access to the following within their network of hospitals: • Level III Obstetrical services; • Level III Neonatal Intensive Care (NICU) services; • Pediatric services; • Trauma services; • Burn services; and • A Children's Hospital that meets the CMS definition in 42CFR, Parts 412 and 413.				Policy and Procedure on page 4 and the Network Development Management Plan on page 15. Missing is reference to "A Children's Hospital that meets the CMS definition in 42CFR, Parts 412 and 413"; however, the MCO reports that they are contracted with every hospital in the state.	
7.8.4.3	The MCO may contract with out-of-state hospitals in the trade area.	P/P for Provider Network GeoAccess reports		Full	This requirement is addressed in the Network Development Management Plan on page 16.	
7.8.4.4	If there are no hospitals within the parish that meet these requirements in section 7.8.4.2.1 or a contract cannot be negotiated, the MCO may contract with out-of-state hospitals to comply with these requirements.	P/P for Provider Network GeoAccess reports		Full	This requirement is addressed in the Network Development Management Plan on page 16.	
7.8.5	**Tertiary Care** Tertiary care is defined as health services provided by highly-specialized providers, such as medical sub-specialists; these services frequently require complex technological and support facilities. The MCO shall provide tertiary care services including trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day. If the MCO does not have a full range of tertiary care services, the MCO shall have a process for providing such services including transfer protocols and arrangements with out-of-network providers.	P/P for use of out-of-network providers P/P for providing access to tertiary care GeoAccess reports		Full	This requirement is addressed in the Network Development Management Plan on page 22.	

Provider Network Requirements						
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7.8.6	**Direct Access to Women's Health Care** The MCO shall provide direct access to a health specialist(s) in-network for core benefits and services necessary to provide women's routine and preventive health care services. This access shall be in addition to the member's PCP if that provider is not a women's health specialist.	P/P for direct access services		Full	This requirement is addressed in the Network Development Management Plan on page 22.	
7.8.6.1	The MCO shall demonstrate its network includes sufficient family planning providers to ensure timely access to covered services.	P/P for direct access services		Full	This requirement is addressed in the Network Development Management Plan on page 16.	
7.8.6.2	The MCO shall notify and give each member, including adolescents, the opportunity to use their own PCP or utilize any family planning service provider for family plannings services without requiring a referral or authorization. Family planning services shall be available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments and traditional contraceptive devices. The MCO family planning services shall also include preconception and interconception care services for members to optimize member health entering pregnancy. The MCO shall agree to make available all family planning services to MCO members as specified in this RFP.	P/P for direct access services ACLA Member Handbook		Full	This requirement is addressed in the member handbook on page 22.	
7.8.6.3	MCO members shall have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the MCO's provider network without any restrictions as specified in 42 CFR §431.51(b)(2). The out-of-network Medicaid enrolled family planning services provider shall bill the MCO and be reimbursed no less than the Medicaid rate in effect on the date of service. MCO members should be encouraged by the MCO to receive family planning services through the MCO's	P/P for direct access services ACLA Member Handbook		Full	This requirement is addressed in the member handbook on page 22.	

Provider Network Requirements						
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	network of providers to ensure continuity and coordination of the member's total care. No additional reimbursements shall be made to the MCO for MCO members who elect to receive family planning services outside the MCO's provider network.					
7.8.6.5	The MCO shall maintain the confidentiality of family planning information and records for each individual member including those of minor patients.	P/P for Direct Access Services		Full	This requirement is addressed in the member handbook on page 22.	
7.8.7 7.8.7.1	**Prenatal Care Services** The MCO shall assist all pregnant members in choosing a pediatrician, or other appropriate PCP, for the care of their newborn babies before the beginning of the last trimester of gestation. In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, the MCO shall provide the member with a minimum of fourteen (14) calendar days after birth to select a PCP prior to assigning one.	P/P for Prenatal Care Services Access P/P for Assignment of PCPs including Auto Assignment		Full	This requirement is addressed in the Assigning Primary Care Physicians and Changing Primary Care Physicians Policy on page 3 and the New Member Education and Communication Policy on page 4.	
7.8.8	**Other Service Providers** The MCO shall ensure the availability of medical service providers including, but not limited to, ambulance services, durable medical equipment, orthotics, prosthetics and certain supplies, and radiology, and laboratories. All services must be provided in accordance with applicable state and federal laws and regulations.	Evidence of availability of other medical service providers		Full	This requirement is addressed in the member handbook on page 23.	
7.8.10 7.8.10.1	**FQHC/RHC Clinic Services** The MCO must offer to contract with all FQHCs and RHCs (both freestanding and hospital-based) in the state.	P/P for Provider Network Contracts with FQHC/RHCs		Full	This requirement is addressed in the Network Development Management Plan on page 17 and in the Practitioner Contracts Policy and Procedure on page 2.	
7.8.11 7.8.11.1	**School-Based Health Clinics (SBHCs)** SBHC (certified by the LDH Office of Public Health) services are those Medicaid services provided within school settings to Medicaid eligible children					

Provider Network Requirements						
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	under the age of 21.					
7.8.11.2	The MCO must offer a contract to each SBHC. The MCO may stipulate that the SBHC follow all of the MCO's required policies and procedures.	P/P for Provider Network Contracts with SBHCs		Full	This requirement is addressed in the Practitioner Contracts Policy on page 2.	
7.8.13 7.8.13.1	**Local Parish Health Clinics** The MCO must offer a contract to the Louisiana Office of Public Health (OPH) for the provision of personal health services offered within the parish health units (e.g. immunizations, STI, family planning).	P/P for Provider Network Contract with Louisiana OPH		Full	This requirement is addressed in the Practitioner Contracts Policy on page 2.	
7.8.13.2	The MCO shall coordinate its public health-related activities with OPH. Coordination mechanisms and operational protocols for addressing public health issues shall be negotiated with OPH and BHSF (Medicaid) and reflect Louisiana public health priorities. The coordination of activities related to public health will take the form of agreements among the parties which may include policy memos or separate memorandums of understanding signed by OPH, BHSF (Medicaid), and the MCO.	P/P for Provider Network Contract with Louisiana OPH		Full	This requirement is addressed in the Network Development Management Plan 2018 Final on pages 16, 17, and 27.	
7.8.14 7.8.14.1	**Specialized Behavioral Health Providers** The MCO shall ensure behavioral health services are offered to address the needs of youth with serious emotional disorders, adults with Serious Mental Illness (SMI), members with substance use disorders, members with co-occurring mental health and substance use disorders and other developmental disorders. This shall include coordination with the Local Governing Entities (LGEs) for the provision of Medicaid services.	P/P provider network P/P care coordination Network reports		Full	This requirement is addressed in the Geo Access Report and ACLHA Ancillary Service Agreement.	
7.8.14.2	The MCO shall ensure its provider network offers a range of preventive and specialized behavioral health services as reflected in the LDH Behavioral Health Provider Manual and meets the network adequacy standards defined in this contract. The					

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	provider network shall be adequate for the anticipated number of members for the service area. The service array shall comply with the waivers and Medicaid State Plan requirements.					
7.8.14.3	The network shall be developed to meet the needs of members, including but not limited to providing assessment to identify and treat the behavioral health needs of members with past history or current display of aggression, runaway behavior, sexual offenses, or intellectual disability.			Full	This requirement is addressed in the Practitioner Contracts Policy and Procedure on page 8 and the Copy of Assessment - Initial Assessment-PEDS.	
7.8.14.4	The MCO shall design its provider network to maximize the availability of community-based behavioral healthcare that reduces utilization of emergency services when lower cost community-based services are available and eliminates preventable hospital admissions. The MCO shall coordinate with other state agencies, as appropriate, to match services to meet behavioral health needs in the community with services and supports to meet the members other needs in the community, such as I/DD.			Full	This requirement is addressed in the Network Development Management Plan on page 25.	.
7.8.14.5	The MCO shall design its provider network to increase the emerging use of peers as providers. This includes peers providing services for youth, adults and parents/families served in community and residential settings, peer services as approved by LDH as cost-effective alternative services, and peer support specialists with OBH approved credentials to serve as qualified providers.	P/P provider network P/P care coordination Network reports		Full	This requirement is addressed in the Network Development Management Plan on page 13 and in 332 ACLA 2018 A (002).	
7.8.14.6	The MCO shall ensure that within the provider network, members enrolled in 1915(c) CSoC Home and Community Based waiver services have a choice of behavioral health providers, which offer the appropriate level of care and may change providers in accordance with Medicaid home and community based waiver requirements pertaining	P/P provider network P/P care coordination Network reports		Full	This requirement is addressed in the Choice in Provider Work Process, and in the Member Choice in Provider form.	

Provider Network Requirements						
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	to Freedom of Choice.					
7.8.14.7	The MCO shall ensure the provider network has a sufficient number of prescribers and other qualified behavioral health service providers to deliver services during evenings and weekends.	P/P provider network P/P care coordination Network reports		Full	This requirement is addressed in the Provider Accessibility and Availability Standards and Compliance Policy and Procedure.	
7.8.14.8	The MCO shall have a fully operational network of behavioral health crisis response providers offering a complete array of crisis services, available twenty-four (24) hours per day, seven (7) days per week. Crisis services shall include an on-call, 24-hour crisis hotline, warm line, crisis counseling crisis intervention and follow up, linkage to ongoing behavioral health management and intervention, mobile crisis teams, and crisis stabilization for children. The MCO may also coordinate with community resources to expand the crisis response. The community-based crisis response system may include, but is not limited to, warmlines, mobile crisis teams, collaboration with law enforcement crisis stabilization in alternative settings, and crisis stabilization/crisis receiving centers for adults. If shortages in provider network sufficiency are identified by LDH, the MCO shall conduct outreach efforts approved by LDH, and take necessary actions to assure member access to medically necessary behavioral health services. The MCO shall execute an ad hoc or single case agreement when a clinical need or a specialized behavioral health service is identified for a member and no network provider is available to meet that particular need. In such cases, all transportation necessary to receive necessary services will be provided and reimbursed through the MCO, including meals and lodging as appropriate.	P/P provider network P/P care coordination Network reports		Full	This requirement is addressed by the Crisis Intervention Center (CIC) contract and Link agreement and Clinical Liaison Single Case Agreement Referral Workflow.	

Provider Network Requirements						
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7.8.14.10	The MCO shall require behavioral health providers to screen for basic medical issues.	P/P provider network P/P care coordination Network reports		Full	This requirement is addressed in the Network Development Management Plan and in on-site discussions with the MCO.	
7.8.14.11	The MCO shall monitor and support development of local provider capacity for the purpose of identifying and filling gaps in service availability.	P/P provider network P/P care coordination Network reports		Full	This requirement is addressed in the 348 BH Geo Access and Network Gap Analysis Q4 2018.	
7.8.14.12	The MCO shall report the number of out-of-state placements as specified by LDH. LDH may require the MCO to take corrective action in the event LDH determines the MCO's rate of out of state placements to be excessive.	P/P provider network P/P care coordination		Full	This requirement is addressed in the 337 ACLA 2018 12 Report.	
7.8.15 7.8.15.1	**Indian Health Care providers (IHCPs)** The MCO shall demonstrate that there are sufficient IHCPs participating in the provider network of the MCO to ensure timely access to services available under the contract from such providers for Indian members who are eligible to receive services.	P/P provider network P/P care coordination Network reports		Full	This requirement is addressed in the Chitimacha primary care provider agreement. The MCO indicated during the on-site visit there was only one IHCP and they were contracted with them.	
7.8.15.2 7.8.15.2.1 7.8.15.2.2 7.8.15.2.3	The IHCPs, whether participating in the MCO network or not, shall be paid for covered services provided to Indian members who are eligible to receive services from such providers as follows: • At a rate negotiated between the MCO and the IHCP; or • In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the MCO would make for the services to a participating provider which is not an IHCP; and • Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR §447.45 and §447.46.					
7.8.15.3	The MCO shall permit any Indian who is enrolled with the MCO and is eligible to receive services from an IHCP primary care provider participating			Full	This requirement is addressed in the Provider Accessibility and Availability Standards and Compliance Policy and	

Provider Network Requirements						
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	as a network provider, to choose that IHCP as his or her PCP, as long as that provider has capacity to provide the services.				Procedure on page 6.	
7.8.15.4	The MCO shall permit Indian members to obtain services covered under the contract from out-of-network IHCPs from whom the member is otherwise eligible to receive such services.			Full	This requirement is addressed in the Provider Accessibility and Availability Standards and Compliance Policy and Procedure on page 6.	
7.8.15.5 7.8.15.5.1 7.8.15.5.2	Where timely access to covered services cannot be ensured due to few or no IHCPs, the MCO will be considered to have met the requirement in paragraph 42 CFR §438.14 (b)(1) if: .3 Indian members are permitted by the MCO to access out-of-state IHCPs; or .4 If this circumstance is deemed to be good cause for disenrollment from the State's Managed Care Program in accordance with 42 CFR §438.56(c).	P/P provider network P/P care coordination Network reports		Substantial	This requirement is addressed in the Provider Accessibility and Availability Standards and Compliance Policy and Procedure on page 5. Missing from the provided documents is an indication of whether members are permitted by ACLA to access out-of-state IHCPs or if this circumstance is deemed to be good cause for disenrollment. **Recommendations** The MCO should address in policy whether: "Indian members are permitted by the MCO to access out-of-state IHCPs; or If this circumstance is deemed to be good cause for disenrollment from the State's Managed Care Program in accordance with 42 CFR §438.56(c)."	ACLA will add this to the Provider Accessibility and Availability Standards and Compliance Policy (#159.201). Also, ACLA has a clinical liaison who completes single case agreements for members who need care and/or treatment out of the state.
7.8.15.6	The MCO shall permit an out-of-network IHCP to refer an Indian member to a network provider.	P/P provider network P/P care coordination Network reports		Full	This requirement is addressed in the Provider Accessibility and Availability Standards and Compliance Policy and Procedure on page 6.	
7.9						
7.9.1	The MCO shall develop and maintain a Provider Network Development and Management Plan which ensures that the provision of core benefits and services will occur [42 CFR 438.207(b)]. The Network Development and Management Plan shall be submitted to LDH as part of the proposal,	Provider Network Development and Management Plan		Full	This requirement is addressed by the Network Development Management Plan.	

Provider Network Requirements						
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	as well as when significant changes occur and annually thereafter. The Network Development and Management Plan shall include the MCO's process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access of all required services included in the Contract. When designing the network of providers, the MCO shall consider the following (42 CFR 438.68):					
7.9.1.1	Anticipated maximum number of Medicaid members;	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Management Plan on page 26.	
7.9.1.2	Expected utilization of services, taking into consideration the characteristics and health care needs of the members in the MCO;	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Management Plan on page 26.	
7.9.1.3	The numbers and types (in terms of training, experience, and specialization) of providers required to furnish Medicaid core benefits and services;	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Management Plan on page 26.	
7.9.1.4	The numbers of MCO providers who are not accepting new MCO members; and	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Management Plan on page 26.	
7.9.1.5	The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for Medicaid enrollees with disabilities.	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Management Plan on page 26.	
7.9.2	The Network Provider Development and Management Plan shall demonstrate access to Services and Benefits as defined in this RFP, access standards in 42 CFR §438.206 and shall include:	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Management Plan on page 26.	
7.9.2.1	Assurance of Adequate Capacity and Services and supporting documentation that demonstrates that it has the capacity to serve the expected	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Management Plan on pages 12 to 13.	

Provider Network Requirements						
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	enrollment in its service area in accordance with the state standards for access to care, including the standards at 42 CFR §438.68 and 438.206(b)					
7.9.2.2	Assurance it offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of members in the service area;	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Management Plan on pages 12 to 13.	
7.9.2.3	Access to Primary Care Providers	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Management Plan on page 12.	
7.9.2.4	Access to Specialists	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Management Plan on page 13.	
7.9.2.5	Access to Hospitals	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Management Plan on pages 14 to 15	
7.9.2.6	Access to Behavioral Health Services	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Management Plan on pages 14 to 20.	
7.9.2.7	Timely Access	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Management Plan on page 33.	
7.9.2.8	Service Area	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Management Plan on page 13.	
7.9.2.9	Other Access Requirements: • Direct Access to Women's Health , • Special Conditions for Prenatal Providers, • Second Opinion • Out-of-Network Providers	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Management Plan on page 13.	
7.9.3	The Network Provider Development and Management Plan shall identify gaps in the MCO's provider network and describe the process by which the MCO shall assure all covered services are delivered to MCO members. Planned interventions to be taken to resolve such gaps	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Management Plan on pages 16 to 20 and on page 13.	

Provider Network Requirements						
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	shall also be included. The MCO shall include the corrective action(s) taken when a network provider fails to comply with timely access requirements.					
7.9.3.1	The MCO shall ensure network capacity sufficient to meet the specialized needs of individuals with dual diagnosis of behavioral health and developmental disabilities, including autism spectrum disorders. The plan shall specifically assess the extent to which the MCO's in-state network is sufficient to meet the needs of this population.	Provider Network Development and Management Plan		Minimal	This requirement was not addressed explicitly in the documentation provided. **Recommendations** The MCO should assess the network capacity to address the needs of individuals with dual diagnosis of behavioral health and developmental disabilities.	ACLA will revise the current language to specifically state "specialized needs of individuals with dual diagnosis of behavioral health and developmental disabilities, including autism spectrum disorders" in several documents. ACLA has increased the provider types of Applied Behavioral Analysis services from 29 when the service was carved in to the plan in March 2018 to a current number of 54 providers. These services are designed for members with specialized needs of behavioral health and developmental disabilities include autism spectrum disorders.
7.9.3.2	Providers specializing in serving individuals with dual diagnosis of behavioral health and developmental disabilities shall be clearly identified in the provider directory.	Provider Network Development and Management Plan Provider Directory		Minimal	This requirement was not addressed explicitly in the documentation provided. **Recommendations** The MCO should clearly identify whether a provider is specialized in serving individuals with a dual diagnosis of behavioral health and developmental disabilities.	In addition to the above statement, ACLA will work to add specifications to clearly identify this in the provider directory.
7.9.4	The MCO shall provide GEO mapping and coding	Provider Network		Full	This requirement is addressed in the Geo	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	of all network providers for each provider type by the deadline specified in the Schedule of Events, to geographically demonstrate network capacity. The MCO shall provide updated GEO coding to LDH quarterly, or upon material change (as defined in the Glossary) or upon request.	Development and Management Plan GeoAccess reports			Access Reports.	
7.9.5	The MCO shall develop and implement Network Development policies and procedures detailing how the MCO will [42 CFR 438.214(a)]:					
7.9.5.1	Communicate and negotiate with the network regarding contractual and/or program changes and requirements;	P/P for Network Development and Management		Full	This requirement is addressed in the Network Development Plan on page 26.	
7.9.5.2	Monitor network compliance with policies and rules of LDH and the MCO, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes;	P/P for Network Development and Management		Full	This requirement is addressed in the Network Development Plan on page 26.	
7.9.5.3	Evaluate the quality of services delivered by the network;	P/P for Network Development and Management		Full	This requirement is addressed in the Network Development Plan on pages 23 to 24.	
7.9.5.4	Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;	P/P for Network Development and Management		Full	This requirement is addressed in the Authorization for Out-of-Network Practitioners and Providers Policy and Procedure on page 2.	
7.9.5.5	Monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English; and	P/P for Network Development and Management		Full	This requirement is addressed in the ACLA CLAS Program Evaluation on page 18.	
7.9.5.6	Process expedited and temporary credentials. Recruit, select, credential, re-credential and contract with providers in a manner that incorporate quality management, utilization, office audits and provider profiling;	P/P for Network Development and Management		Full	This requirement is addressed in the Network Development plan on pages 24 to 29.	
7.9.5.7	Provide training for its providers and maintain	P/P for Network		Full	This requirement is addressed in the	

Provider Network Requirements						
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	records of such training;	Development and Management			Network Development Plan and the Regional Provider Training Sign-In.	
7.9.5.8	Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;	P/P for Network Development and Management		Full	This requirement is addressed in the Network Development Management Plan on page 26 and in the Provider Complaint and Disputes Processing and Resolution Policy on page 8.	
7.9.5.9	Ensure that provider complaints are acknowledged within 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 business days of receipt (this includes referrals from LDH). If not resolved in 30 days the MCO must document why the issue goes unresolved; however, the issue must be resolved within 90 days.	P/P for Network Development and Management		Full	This requirement is addressed in the Network Development Management Plan on page 25.	
7.9.6	An evaluation of the initial Network Provider Development and Management Plan, including evaluation of the success of proposed interventions and any needed revisions, shall be submitted to LDH at the end of the first year of operations and annually thereafter.	P/P for Evaluation of Network Provider Development and Management Plan		Full	This requirement is addressed in the 2018 Network Adequacy Report.	
7.9.7	MCO Network Development and Management policies shall be subject to approval by LDH, Medicaid Managed Care Section and shall be monitored through operational audits.	Evidence of submission of P/P for Network Development and Management to LDH		Full	This requirement is addressed in the 053 NW Provider Development Management Plan. Evidence of submission.	
7.9.8	**Specialized Behavioral Health Network Development and Management Plan** An initial Network Development and Management Plan focusing on specialized behavioral health providers shall be submitted to LDH by November 1, 2015. Thereafter, the Specialized Behavioral Health network shall be included in a distinct section of the overall MCO Network Development and Management Plan which shall be updated at least annually or more often as needed to reflect	Network development Implementation plan P/P provider network		Full	This requirement is addressed in the Network Development Management Plan Resubmit on pages 13 to 15.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	material changes in networks tatus.					
7.9.8.1	The plan shall contain separate sections for each specialized behavioral health provider type for all covered specialized behavioral health services for both children and adults, and satisfy all service delivery requirements described in this contract	Network development Implementation plan P/P provider network		Full	This requirement is addressed in the Network Development Management Plan 2018 Resubmit on pages 13 to 15.	
7.9.8.2	The MCO's Network Development and Management Plan shall include the following requirements for specialized behavioral health providers: • The methodology the MCO will use for the evaluation of specialized behavioral health providers' ability to perform activities associated with this contract;	Network development Implementation plan P/P provider network		Full	This requirement is addressed in the Network Development Management Plan 2018 Resubmit on pages 30 to 31.	
	• The numbers and types (in terms of training, experience, and specialization) of specialized behavioral health providers required to furnish the contracted specialized behavioral health services, including providers of specialized services (e.g., DD population, sexual offending behaviors, and early childhood development);	Network development Implementation plan P/P provider network		Full	This requirement is addressed in the Network Development Management Plan 2018 Resubmit on pages 24 to 27.	
	• GEO mapping and coding of all specialized behavioral health network providers for each specialized behavioral health provider type to geographically demonstrate network capacity. The MCO shall provide updated GEO mapping and coding to LDH quarterly by contract year, upon material change of the network, or upon request;	Network development Implementation plan P/P provider network		Full	This requirement is addressed in the Provider Availability Standards Analysis Policy and Procedure on page 1 and the 220 PH Geo Access Reports and Network Gap Analysis for Q4 2018 (sample).	
	• An annual needs assessment to identify unmet service needs in the specialized behavioral health service delivery system. The needs assessment shall analyze and include: • Volume of single case agreements and out-of-network, out-of-state and telemedicine	P/P network Needs assessment findings		Full	This requirement is addressed in the 2018 Unmet Service Needs Resolution Plan for Specialized Behavioral Health Service Delivery System Report.	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	referrals for specialized behavioral health services; • Specialized behavioral health service needs of members; and • Growth trends in eligibility and enrollment, including: ○ Current and anticipated numbers of Title XIX and Title XXI eligibles; and ○ Current and desired specialized behavioral health service utilization trends, including prevalent diagnoses, age, gender, and race/ethnicity characteristics of the enrolled population by region; best practice approaches; and network and contracting models consistent with LDH goals and principles.					
	• Accessibility of services, including: ○ The number of current qualified specialized behavioral health service providers by individual specialized behavioral health service in the network who are not accepting new Medicaid referrals and a plan for updating on a regular, reoccurring basis as close to real time as possible; ○ The geographic location of specialized behavioral health providers and members considering distance, travel time, and available means of transportation; ○ Availability of specialized behavioral health services and appointments with physical access for persons with disabilities; and ○ Any service access standards detailed in a SPA or waiver.	Network development Implementation plan P/P provider network		Full	This requirement is addressed in the Network Development Management Plan 2018 Resubmit on pages 14 to 15.	
7.9.8.3	The MCO shall submit to LDH as part of its annual	Evidence of submission of		Full	This requirement is addressed in the	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	Network Development and Management Plan, and upon request of LDH, specialized behavioral health provider profiling data, which shall include: • Member eligibility/enrollment data; • Specialized behavioral health service utilization data; • The number of single case agreements by specialized behavioral health service type; • Specialized behavioral health treatment and functional outcome data; • The number of members diagnosed with developmental/cognitive disabilities; • The number of prescribers required to meet specialized behavioral health members' medication needs; • The efforts given to recruit specialized behavioral health providers and specialty providers to address any unmet need; • Provider grievance, appeal and request for arbitration data; and • Issues, concerns and requests identified by other state agency personnel, local agencies and community stakeholders.	network development Plan to LDH Network Development Management Plan			Network Development Management Plan 2018 Resubmit.	
7.9.8.4	For adults, the MCO shall include in its Network Development and Management Plan strategies for continued transformation of the specialized behavioral health service delivery system into a comprehensive system that: • Includes qualified specialized behavioral health service providers and community resources designed and contracted to deliver specialized behavioral healthcare that is strength-based, community-based, and culturally competent; • Includes specific specialized behavioral health services for adults eligible for services as	Network development and management plan		Full	This requirement is addressed in the Network Development Management Plan 2018 Resubmit on pages 15 to 18.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	defined in this contract; • Is of sufficient size and scope to offer members a choice of providers for all covered specialized behavioral health services; • Makes uniformly available over time recognized EBPs, best practices and culturally competent services that promote resiliency through nationally recognized integrated service models; and • Provides adequate, proactive development and monitoring of community-based options that limit reliance on hospital based services.					
7.9.8.5	For children, the MCO shall include in its Network Development and Management Plan strategies for continued transformation of the specialized behavioral health service delivery system into a comprehensive system that includes the above elements for adults as well as: • Includes specific specialized behavioral health services for children; • Targets the development of family and community-based services for children/youth in out-of-home placements; • Increases access to family and community-based services, optimizing the use of natural and informal supports and reduces reliance on out-of- home placements; and • Provides adequate, proactive development and monitoring of in-state regional out-of-home options to serve the needs of youth in the state.	Network development and management plan		Full	This requirement is addressed in the Network Development Management Plan 2018 Resubmit on pages 15 to 16.	
7.9.8.6	The Network Development and Management Plan shall state that the MCO's provider network meets requirements with regard to cultural competence and linguistics as follows:	Network development and management plan		Full	This requirement is addressed in the Network Development Management Plan on page 42, and Medicaid Managed Care Provider Satisfaction Survey 2018, and 2019 Behavioral Health Member Survey Results.	

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

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	for a minimum of three (3) hours per year and as directed by the needs assessments.					
7.9.8.7	The Network Development and Management Plan shall be inclusive of an evaluation of the initial Network Development and Management Plan in each subsequent year, which shall include evaluation of the success of proposed interventions, barriers to implementation, and any needed revisions pertaining to the delivery of specialized behavioral healthcare.	Network development and management plan		Full	This requirement is addressed in the Network Development Management Plan Resubmit 2018 on pages 4 to 8.	
7.11						
7.11.1	The MCO shall provide written notice to LDH, no later than seven (7) business days of any network provider contract termination that materially impacts the MCO's provider network, whether terminated by the MCO or the provider, and such notice shall include the reason(s) for the proposed action. A material change is defined as one which affects, or can reasonably be foreseen to affect, the MCO's ability to meet the performance and network standards as described in the Contract, including but not limited to the following: • Any change that would cause more than five percent (5%) of members within the service area to change the location where services are received or rendered. • A decrease in the total of individual PCPs by more than five percent (5%); • A loss of any participating specialist which may impair or deny the members' adequate access to providers; • A loss of a hospital in an area where another MCO hospital of equal service ability is not available as required by access standards specified in this RFP; or	Evidence of communications with LDH P/P provider contracting		Full	This requirement is addressed in the Network Adequacy Policy and Procedure on pages 6 to 7. MCO was not required to provide notice during review period.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	• Other adverse changes to the composition of the MCO which impair or deny the members' adequate access to providers.					
7.11.2	The MCO shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in value-added benefits and services, payments, or eligibility of a new population.	Evidence of communication with LDH P/P Provider network		Full	This requirement is addressed in the Network Adequacy Policy and Procedure on page 6. MCO was not required to submit during review period.	
7.11.3	When the MCO has advance knowledge that a material change will occur, the MCO must submit a request for approval of the material change in their provider network, including a copy of draft notification to affected members, sixty (60) days prior to the expected implementation of the change.	Request for approval communications Notification to Member		Full	This requirement is addressed in the Network Adequacy Policy and Procedure on page 7. MCO was not required to submit during review period.	
7.11.4	The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them.	Request for approval		Full	This requirement is addressed in the Network Adequacy Policy and Procedure on page 7.	
7.11.5	If LDH does not respond within thirty (30) days the request and the notice are deemed approved. A material change in the MCO's provider network requires thirty (30) days advance written notice to affected members. For emergency situations, LDH will expedite the approval process.					
7.11.6	The MCO shall notify the LDH/BHSF/Medicaid Managed Care Section within one (1) business day of the MCO becoming aware of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair	Notification to LDH P/P provider network		Full	This requirement is addressed in the Network Adequacy Policy and Procedure. The MCO indicated during on-site that there were no unexpected changes that would impair the provider network.	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	its provider network [42 CFR §438.207(c)]. The notification shall include: • Information about how the provider network change will affect the delivery of covered services, and • The MCO's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.					
7.11.7	MCO's shall give hospitals and provider groups ninety (90) days' notice prior to a contract termination without cause. Contracts between the MCO and single practitioners are exempt from this requirement.	Provider contracts P/P provider contracting		Full	This requirement is addressed in the Network Adequacy Policy and Procedure on page 4.	
7.11.8 7.11.8.1	As it pertains to a material change in the network for behavioral health providers, the MCO shall also: .1 Provide written notice to LDH, no later than seven (7) business days of any behavioral health network provider contract termination that materially impacts the MCO's provider network, whether terminated by the MCO or the provider, and such notice shall include the reason(s) for the proposed action. Material changes in addition to those noted in Section 7.11 include: • A decrease in a behavioral health provider type by more than five percent (5%); • A loss of any participating behavioral health specialist which may impair or deny the members' adequate access to providers; or • A loss of a hospital or residential treatment in an area where another provider of equal service ability is not available as required by access standards approved by LDH.	Evidence of notifications P/P provider network		Full	This requirement is addressed in the Network Adequacy Policy and Procedure. The MCO indicated that there were no material changes in the network during the review period.	
7.11.8.2	The MCO shall provide or arrange for medically necessary covered services should the network	P/P provider network		Full	This requirement is addressed in the Network Adequacy Policy and Procedure on	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	become temporarily insufficient within a service area.				page 7.	
7.11.8.3 7.11.8.3.1	When the MCO has advance knowledge that a material change will occur to its network of behavioral health providers, the MCO must submit a written request for approval of the material change in their provider network to LDH, including a copy of draft notification to affected members, sixty (60) calendar days prior to the expected implementation of the change. .1 The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them, including: • Detailed information identifying the affected provider; • Demographic information and number of members currently served and impacted by the event or material change, including the number of Medicaid members affected by program category; • Location and identification of nearest providers offering similar services; and • A plan for clinical team meetings with the member, his/her family/caregiver, and other persons requested by the member and/or legal guardian to discuss available options and revise the service plan to address any changes in services or service providers.	Request for approval letter		Full	This requirement is addressed in the Network Adequacy Policy and Procedure on page 7. The MCO indicated during the on-site that there were no material changes to the network during the review period.	
7.11.8.4	If a provider loss results in a material gap or behavioral health network deficiency, the MCO shall submit to LDH a written plan with time frames and action steps for correcting the gap or deficiency within thirty (30) calendar days that includes the transitioning of members to	Written plan P/P provider network		Full	This requirement is addressed in the Network Adequacy Policy and Procedure on page 7.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	appropriate alternative behavioral health service providers in accordance with the network notification requirements.					
7.11.8.5	The MCO shall track all members transitioned due to a subcontract's suspension, limitation, termination, or material change to ensure behavioral health service continuity and provide member information as requested by LDH (e.g., name, Title XIX or Title XXI status, date of birth, services member is receiving or will be receiving, name of new provider, date of first appointment, and activities to re-engage persons who miss their first appointment with the new provider).	Tracking report P/P service coordination		Full	This requirement is addressed in the Network Adequacy Policy and Procedure on page 7 and the Tracking Termed Providers Transition Plan. The MCO provided evidence of a transition report during the on-site visit.	
7.12						
7.12.0	The MCO shall encourage network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid members. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; Aging and Disability Councils; Areas on Aging; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).	P/P for Coordination with Other Service Providers		Full	This requirement is addressed in the Network Development Management Plan on page 16 and 25.	
7.13						
7.13.2.2	The MCO provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	P/P for Network Management P/P for Provider Selection and Retention		Full	This requirement is addressed in the Network Adequacy Policy and Procedure on page 28.	
7.14						
7.14.1	The MCO must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12, §438.206, §438.214, §438.224, §438.230 and NCQA health plan Accreditation Standards for	P/P for credentialing & recredentialing		Full	This requirement is addressed in the Credentialing/Re-credentialing of Practitioners Policy and Procedure, and in the Organizational Provider Credentialing	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	the review, credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the MCO selects and directs its members to see a specific provider or group of providers. These procedures shall be submitted to LDH within sixty (60) calendar days after contract amendment, when a change is made, and annually thereafter by contract year.				and Recertification Process Policy and Procedure.	
7.14.1.1	Prior to contracting, the MCO shall credential providers to ensure provider facilities, organizations, and staff meet all qualifications and requirements established by LDH including but not limited to the Medicaid Behavioral Health Provider Manual, state and federal laws, and rules and regulations for all specialized behavioral health providers. MCO credentialing files on providers shall include verification of meeting said requirements. This shall include that agencies offering mental health rehabilitation services (CPST, PSR and/or CI), Assertive Community Treatment (ACT), PRTFs, TGHs and SUD residential treatment facilities to supply proof of accreditation by an LDH approved accrediting body, which shall be made part of the agency's credentialing file with the MCO. Agencies not accredited at the time of credentialing shall supply proof that the agency applied for accreditation and paid the initial application fee Agencies must present proof of full accreditation within eighteen (18) months following the initial contracting date with the MCO. Specialized behavioral health provider types required to be accredited by rule, regulation, waiver or State Plan Amendment (SPA) prior to contracting or prior to receiving Medicaid	P/P provider contracting		Full	This requirement is addressed in the facility credentialing application packet, and Standardized Credentialing Application.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	reimbursement, shall have proof of accreditation on file with the MCO. LDH approved national accrediting bodies include: • The Council on Accreditation (COA); • The Commission on Accreditation of Rehabilitation Facilities (CARF); or • The Joint Commission (TJC).					
7.14.2	The MCO shall use the Louisiana Standardized Credentialing Application Form (Appendix F) or Council for Affordable Quality Healthcare (CAQH) standardized credentialing form. The MCO must allow providers to use CAQH if available for their provider type.	P/P for credentialing & recredentialing Includes Credentialing/Recredentialing File Review		Full	This requirement is addressed by Credentialing/Recredentialing of Practitioners Policy and Procedure on page 4. On-site file reviews verified the MCO follows credentialing standards, such as verification of current licenses, work history, malpractice coverage, and professional liability claims history, education or board certification verification, DEA/CDS certifications, exclusion lists, state, federal, Medicare, and Medicaid sanctions including those published or maintained by OIG, AMA, or NPDB. For re-credentialing files, the files were verified for timeliness of re-credentialing, board-certifications if applicable, current licenses, valid DEA/CDS certifications if any, and the attestation.' **File Review Results** Five (5) of five (5) credentialing and five (5) of five (5) re-credentialing files reviewed met this requirement.	
7.14.3	The MCO shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and re-credentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	P/P for credentialing & recredentialing Includes Credentialing/Recredentialing File Review		Full	This requirement is addressed in the Credentialing/Re-credentialing of Practitioners Policy and Procedure on page 3. **File Review Results** Five (5) of five (5) credentialing and five (5)	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					of five (5) re-credentialing files reviewed met this requirement.	
7.14.4	If the MCO has NCQA health plan Accreditation those credentialing policies and procedures shall meet LDH's credentialing requirements.	P/P for credentialing & recredentialing		Full	This requirement is addressed in the Credentialing/Re-credentialing of Practitioners Policy and Procedure on page 3	
7.14.5	The MCO shall completely process credentialing applications from all types of provider types within sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. "Completely process" shall mean that the MCO shall:	P/P for credentialing & recredentialing P/P for subcontractor delegation and requirements Credentialing subcontractor contract Includes Credentialing/Recredentialing File Review		Full	This requirement is addressed in Credentialing/Recredentialing of Practitioners Policy and Procedure on page 6. **File Review Results** Five (5) of five (5) credentialing files reviewed met this requirement.	
7.14.5.1	Review, approve and load approved applicants to its provider files in its claims processing system; and	P/P for credentialing & recredentialing		Full	This requirement is addressed in the New Provider/Practitioner Load /Data Update-Change Policy and Procedure on page 4.	
7.14.5.2	Submit on the weekly electronic Provider Directory to LDH or LDH's designee; or	P/P for credentialing & recredentialing Provider Directory Evidence of submission of the Provider Directory		Full	This requirement is addressed in the New Provider/Practitioner Load /Data Update-Change Policy and Procedure on page 4.	
7.14.5.3	Deny the application and assure that the provider is not used by the MCO.	P/P for credentialing & recredentialing		Full	This requirement is addressed in the Credentialing/Re-credentialing of Practitioners Policy and Procedure.	
7.14.6	If the MCO has delegated credentialing to a subcontractor, there shall be a written description of the delegation of credentialing activities within the contract. The MCO must require that the subcontractor provide assurance that all licensed medical professionals are credentialed in accordance with LDH's credentialing requirements.	P/P for credentialing & recredentialing Delegation Contracts		Full	This requirement is addressed in the Credentialing Delegation Agreement pages 1 and 16.	
7.14.7	The MCO shall not delegate credentialing of	P/P for credentialing &		Minimal	This requirement is addressed in the	ACLA does not have any

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	specialized behavioral health providers unless approved by LDH in advance.	recredentialing			Credentialing/Re-credentialing of Practitioners. Missing from the supplied documents is the requirement that the MCO shall not delegate credentialing of specialized behavioral health providers unless approved by LDH in advance. **Recommendation** The MCO should indicate in the policy that they will not delegate credentialing of specialized behavioral health providers unless approved by LDH in advance.	specialized behavioral health providers delegated at this time. However, ACLA will add this to the Credentialing and Recredentialing of Practitioners Policy (#CP 210.104).
7.14.8	To the extent the MCO has delegated credentialing agreements in place with any approved delegated credentialing agency, the MCO shall ensure all providers submitted to the MCO from the delegated credentialing agent is loaded to its provider files and into its claims processing system within thirty (30) calendar days of receipt.	P/P for credentialing & recredentialing		Full	This requirement is addressed in the Provider/Practitioner Load /Data Update-Change Policy and Procedure on page 4.	
7.14.9	The MCO shall notify LDH when the MCO denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.	P/P for credentialing & recredentialing		Full	This requirement is addressed in the Credentialing/Re-credentialing of Practitioners Policy and Procedure on page 15.	
7.14.10	The process of periodic re-credentialing shall be completed at least once every three (3) years.	P/P for credentialing & recredentialing		Full	This requirement is addressed in Credentialing/Recredentialing of Practitioners Policy and Procedure on page 25. **File Review Results** Five (5) of five (5) re-credentialing files reviewed met this requirement.	
7.14.11	The MCO shall develop and implement policies and procedures for approval of new providers, and termination or suspension of providers to	P/P for credentialing & recredentialing		Full	This requirement is addressed in the Credentialing/Re-credentialing of Practitioners Policy and Procedure on pages	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	assure compliance with the Contract. The policies and procedures should include but are not limited to the encouragement of applicable board certification.				13 to 15.	
7.14.12	The MCO shall develop and implement a mechanism, subject to LDH approval, for reporting quality deficiencies which result in suspension or termination of a network provider/ subcontractor(s). This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.	P/P for credentialing & recredentialing P/P for reporting provider quality deficiencies Documented process for reporting quality deficiencies resulting in suspension or termination		Full	This requirement is addressed in the Credentialing/Re-credentialing Provider Denial, Termination or Reconsideration Appeal Process Policy and Procedure on page 7.	
7.14.13	The MCO shall develop and implement a provider dispute and appeal process, with LDH's approval, for sanctions, suspensions, and terminations imposed by the MCO against network provider/contractor(s) as specified in the Contract. This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.	P/P for credentialing & recredentialing P/P for provider dispute and appeal process Documented provider dispute and resolution process for sanctions, suspensions and terminations Evidence of timely process submission		Full	This requirement is addressed the in Credentialing/Re-credentialing Provider Denial, Termination or Reconsideration Appeal Process Policy and Procedure.	
7.14.14	The State reserves the right to contract with a single Credential Verification Organization (CVO). If this option is pursued, MCOs and their subcontractors shall agree to use the CVO for the credentialing and recredentialing of all participating providers. The MCO will be given at least 90 days' notice before implementation of any CVO contract.					
7.16						
7.16.1	Subject to the limitations in 42 CFR §438.102(a)(2), the MCO shall not prohibit or	P/P for Communication of Anti-gag Clause		Full	This requirement is addressed in the provider handbook on page 102.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether the benefits for such care or treatment are provided under the Contract, for the following:	ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts				
7.16.1.1	The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;	P/P for Communication of Anti-gag Clause ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts		Full	This requirement is addressed in the provider handbook on page 102.	
7.16.1.2	Any information the member needs in order to decide among relevant treatment options;	P/P for Communication of Anti-gag Clause ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts		Full	This requirement is addressed in the provider handbook on page 102.	
7.16.1.3	The risks, benefits and consequences of treatment or non-treatment; and	P/P for Communication of Anti-gag Clause ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts		Full	This requirement is addressed in the provider handbook on page 102.	
7.16.1.4	The member's right to participate in decisions regarding their health care, including, the right to refuse treatment, and to express preferences about future treatment decisions.	P/P for Communication of Anti-gag Clause ACLA ACLA Provider Handbook_January 2019 Update/Manual Provider contracts		Full	This requirement is addressed in the provider handbook on page 102.	
7.16.1.5	Any MCO that violates the anti-gag provisions set forth in 42 U.S.C §438.102(a)(1) shall be subject to intermediate sanctions.					
7.16.1.6	The MCO shall comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including	P/P for Communication of Anti-gag Clause ACLA ACLA Provider		Full	This requirement is addressed in the Specialty Care Provider Agreement on page 15.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	interference with provider's advice to members and information disclosure requirements related to physician incentive plans.	Handbook_January 2019 Update/Manual Provider contracts ACLA Member Handbook				

Utilization Management

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
8.1	**General Requirements**					
8.1.1	The MCO shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review and Service Authorization. The MCO shall submit UM policies and procedures to LDH for written approval within thirty (30) days from the date the Contract is signed, annually thereafter, and prior to any revisions.	P/P for UM Evidence of timely submission of P/P for UM		Full	This requirement is addressed in UM Program Description on pages 3 and 4; ACLA UM.008L Clinical Criteria, page 1; and UM.003L Standard and Urgent Prior Authorization Policy, page 1-8.	
8.1.2	The UM Program policies and procedures shall meet all NCQA standards and include medical management criteria and practice guidelines that:					
8.1.2.1	Are adopted in consultation with contracting health care professionals;	P/P for UM		Full	This requirement is addressed in the P/P UM.008L Clinical Criteria Policy, page 1.	
8.1.2.2	Are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;	P/P for UM		Full	This requirement is addressed in the P/P UM.008L Clinical Criteria Policy, page 1.	
8.1.2.3	Are considerate of the needs of the members; and	P/P for UM		Full	This requirement is addressed in the P/P UM.008L Clinical Criteria Policy, page 6 of 8.	
8.1.2.4	Are reviewed annually and updated periodically as appropriate.	P/P for UM		Full	This requirement is addressed in the UM Program Description, page 5 of 22, and the P/P UM.008L Clinical Criteria Policy, page 1.	
8.1.3	The policies and procedures shall include, but not be limited to:					
8.1.3.1	The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;	P/P for UM		Full	This requirement is addressed in 153.003 Standard and Urgent Prior Authorization, page 3-5, and 153.002 Concurrent Review 2019, page 1-3.	
8.1.3.2	The data sources and clinical review criteria used in decision making;	P/P for UM		Full	This requirement is addressed in 153.008 Clinical Criteria, page 1.	
8.1.3.3	The appropriateness of clinical review shall be fully documented;	P/P for UM		Full	This requirement is addressed in 153.008 Clinical Criteria, page 1.	
8.1.3.4	The process for conducting informal reconsiderations for adverse determinations;	P/P for UM		Full	This requirement is addressed in 153.105 Peer-to-Peer Discussion, page 1.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
8.1.3.5	Mechanisms to ensure consistent application of review criteria and compatible decisions;	P/P for UM		Full	This requirement is addressed in 153.708 Inter-Rater Reliability, page 1.	
8.1.3.6	Data collection processes and analytical methods used in assessing utilization of health care services;	P/P for UM		Full	This requirement is addressed in 153.003L Standard and Urgent Prior Authorization, see entire Policy section, pages 1-3, and 153.008 Clinical Criteria, page 1.	
8.1.3.7	Provisions for assuring confidentiality of clinical and proprietary information;	P/P for UM		Full	This requirement is addressed in 153.008 Clinical Criteria, Policy section, page 4.	
8.1.3.8	Service authorization criteria for specialized behavioral health services that are consistent with the Medicaid State Plan;	P/P for UM P/P Coordination of services		Full	This requirement is addressed in 153.008 Clinical Criteria, Policy section, page 2, #2m.	
8.1.3.9	Collaborating with OJJ, DCFS and schools to coordinate the discharge and transition of children and youth in out-of-home placement for the continuance of prescribed medication and other behavioral health services prior to reentry into the community, including the referral to necessary providers or a WAA if indicated;	P/P for UM P/P Coordination of services		Full	This requirement is addressed in 151.103 Managing Medications that Require Authorization for a Member Being Discharged from a Behavioral Health Facility, pages 1-2, and 156.800 Care Transition: Discharge Planning, pages 2, 3, and 6, and examples given of coordination of care and transitions.	
8.1.3.10	Collaborating with hospitals, nursing home facilities, and inpatient facilities to coordinate aftercare planning prior to discharge and transition of members for the continuance of behavioral health services and medication prior to reentry into the community, including referral to community providers;	P/P for UM P/P Coordination of services		Full	This requirement is addressed in Policy 151.103 Managing Medications that Require Authorization for a Member Being Discharged from a Behavioral Health Facility, pages 1–2, and Policy 156.800: Care Transition: Discharge Planning, pages 2, 3, and 6, and process discussed by CO.	
8.1.3.11	Collaborating with the Department of Corrections and criminal justice system in Louisiana to facilitate access to and/or continuation of prescribed medication and other behavioral health services prior to reentry into the community, including referral to community providers; and	P/P for UM P/P Coordination of services		Full	This requirement is addressed in Policy 151.103 Managing Medications that Require Authorization for a Member Being Discharged from a Behavioral Health Facility, pages 1–2, and Policy 156.800: Care Transition: Discharge Planning, pages 2, 3, and 6.	
8.1.3.12	Collaborating with nursing facilities in Louisiana to coordinate the discharge and transition of	P/P for UM P/P Coordination of		Full	This requirement is addressed in Policy 151.103 Managing Medications that Require	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	members into the community for continuance of prescribed medication and other behavioral health services prior to re-entry into the community, including referral to community providers.	services			Authorization for a Member Being Discharged from a Behavioral Health Facility, pages 1–2, and Policy 156.800: Care Transition: Discharge Planning, pages 2, 3, and 6.	
8.1.4	The MCO shall coordinate the development of clinical practice guidelines with other LDH MCOs to avoid providers receiving conflicting practice guidelines from different MCOs.	P/P for UM P/P for guideline development coordination P/P for guideline research, selection, adoption, review, update, & update schedule Sample adopted guidelines		Full	This requirement is addressed in Common Hospital Observation Policy, page 1, paragraph 1, which addresses Hospital Observation Beds and committee minutes and attendance rosters provided.	
8.1.5	The MCO shall disseminate the practice guidelines to all affected providers and, upon request, to members and potential members.	P/P for UM P/P for guideline dissemination Sample adopted guidelines		Full	This requirement is addressed in ACLA UM.008L Clinical Criteria, page 6, and the provider handbook, page 30.	
8.1.5.1	The MCO shall take steps to require adoption of the clinical practice guidelines by subcontracted specialized behavioral health care providers, and to measure compliance with the guidelines, until such point that ninety percent (90%) or more of the providers consistently achieve eighty percent (80%) compliance, based on MCO measurement findings. The MCO should employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance .	Provider contracts Compliance reports		Full	This requirement is addressed in All Provider contracts – Section 9, and Compliance Reports.	
8.1.6	The MCO must identify the source of the medical management criteria used for the review of service authorization requests, including but not limited to:	P/P for UM P/P for medical management criteria		Full	This requirement is addressed in 153.008 Clinical Criteria, pages 2-3.	
8.1.6.1	The vendor must be identified if the criteria was purchased;	P/P for UMP/P for medical management criteria		Full	This requirement is addressed in 153.008 Clinical Criteria, pages 2-3.	
8.1.6.2	The association or society must be identified if the criteria are developed/recommended or endorsed	P/P for UM P/P for medical		Full	This requirement is addressed in 153.008 Clinical Criteria, pages 2-3.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	by a national or state health care provider association or society;	management criteria				
8.1.6.3	The guideline source must be identified if the criteria are based on national best practice guidelines; and	P/P for UM P/P for medical management criteria		Full	This requirement is addressed in 153.008 Clinical Criteria, pages 2-3.	
8.1.6.4	The individuals who will make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the MCO medical director or other qualified and trained professionals.	P/P for UM P/P for medical management criteria		Full	This requirement is addressed in 153.003 Standard and Urgent, page 3.	
8.1.7	UM Program medical management criteria and practice guidelines shall be posted to the MCO's website. If the MCO uses proprietary software that requires a license and may not be posted publicly according to associated licensure restrictions, the MCO may post the name of the software only on its website. Upon request by an enrollee, their representative, or LDH, the MCO must provide the specific criteria and practice guidelines utilized to make a decision and may not refuse to provide such information on the grounds that it is proprietary. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines applys hould be consistent with the guidelines.	P/P for UM P/P for guideline dissemination		Full	This requirement is addressed in 153.008 Clinical Criteria, pages 2-3 (McKesson Interqual) used and Behavioral Health Services Provider Manual (Specialized Behavioral Health Manual).	
8.1.8	The MCO shall have written procedures listing the information required from a member or health care provider in order to make medical necessity determinations. Such procedures shall be given verbally to the covered person or health care provider when requested. The procedures shall outline the process to be followed in the event the MCO determines the need for additional information not initially requested.	P/P for UM P/P for required information P/P for additional information		Full	This requirement is addressed in 153.002 Concurrent Review, page 5, and 153.003 Standard and Urgent Prior (Pre-Service) Authorization, pages 5-6.	
8.1.9	The MCO shall have written procedures to address the failure or inability of a provider or member to	P/P for UM		Full	This requirement is addressed in ACLA UM.003L Standard and Urgent Prior (Pre-	

Utilization Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	provide all the necessary information for review. In cases where the provider or member will not release necessary information, the MCO may deny authorization of the requested service(s) within two (2) business days.				Service) Authorization, Procedure section, page 6, #8.	
8.1.10 8.1.10.1 8.1.10.2	The MCO shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines. The MCO shall provide UM staff specifically assigned to: • Specialized behavioral health services, and • PSH to ensure appropriate authorization of tenancy services.	P/P for UM Staffing plan		Full	This requirement is addressed in ACLA 2019 UM Program Description, Utilization Management Staffing section, pages 8 – 9, under Staff Roles and Responsibilities section, pages 10-18, and 153.003 Standard and Urgent Prior Authorization, Policy section, page 3, and credentials of staff and annual training meetings.	
8.1.11	The MCO shall use LDH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for medical necessity determinations. The MCO shall make medical necessity determinations that are consistent with the State's definition.	P/P for UM		Full	This requirement is addressed in 153.008 Clinical Criteria, page 5, Definition.	
8.1.13	The MCO must identify the qualification of staff who will determine medical necessity.	P/P for UM Staffing plan		Full	This requirement is addressed in 153.008 Clinical Criteria, page 5, Definition.	
8.1.14	Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.	P/P for UM		Full	This requirement is addressed in 153.003 Standard and Urgent Prior (Pre-Service) Authorization, page 2.	
8.1.15	The MCO shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.	P/P for UM Includes UM File Review		Full	This requirement is addressed in 153.003 Standard and Urgent Prior (Pre-Service) Authorization, page 2. **BH/UM Denial File Review** Ten (10) files reviewed and 10 files compliant.	
8.1.16	The individual(s) making these determinations shall have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency	P/P for UM		Full	This requirement is addressed in 153.003 Standard and Urgent Prior (Pre-Service) Authorization, page 2.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.					
8.1.17	The individual making these determinations is required to attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise.	P/P for UM		Full	This requirement is addressed in 153.003 Standard and Urgent Prior (Pre-Service) Authorization, page 2.	
8.1.18	The MCO shall provide a mechanism to reduce inappropriate and duplicative use of health care services. Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan. The MCO shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member. The MCO may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210.	P/P for UM		Full	This requirement is addressed in 153.003 Standard and Urgent Prior (Pre-Service) Authorization, page 2.	
8.1.21	The MCO shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210.	P/P for UM		Full	This requirement is addressed in 153.003 Standard and Urgent Prior (Pre-Service) Authorization, page 2.	
8.4	**Service Authorization**					
8.4.1	Service authorization includes, but is not limited to, prior authorization, concurrent authorization	P/P for UM P/P for service		Full	This requirement is addressed in ACLA 2019 UM Program Description, page 5.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	and post authorization.	authorization				
8.4.2	The MCO UM Program policies and procedures shall include service authorization policies and procedures consistent with 42 CFR §438.210, 42 CFR §441 Subpart D, state laws and regulations, Medicaid State Plan and waivers, and the court-ordered requirements of *Chisholm v. Gee and Wells v. Gee* for initial and continuing authorization of services that include, but are not limited to, the following:	P/P for UM P/P for service authorization (Chisholm v Gee-Services to autism spectrum disorder)		Full	This requirement is addressed in 153.003 Standard and Urgent Prior (Pre-Service) Authorization, page 1.	
8.4.2.1	Written policies and procedures for processing requests for initial and continuing authorizations of services, where a service authorization member's request is for the provision of a service if a provider refuses a service or does not request a service in a timely manner;	P/P for UM P/P for service authorization		Full	This requirement is addressed in 153.003 Standard and Urgent Prior (Pre-Service) Authorization, page 1.	
8.4.2.2	Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;	P/P for UM P/P for service authorization		Full	This requirement is addressed in 153.708 Inter-Rater Reliability, page 1, and 153.105 Peer to Peer Discussion, pages 1-3.	
8.4.2.3	Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease;	P/P for UM P/P for service authorization		Full	This requirement is addressed in ACLA UM.003L Standard and Urgent Prior Authorization Policy section, pages 2-3, and Procedures section #10-13, page 6.	
8.4.2.4	Provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process shall be included in its member manual and incorporated in the grievance procedures;	P/P for UM P/P for service authorization		Full	This requirement is addressed in 153.003 Standard and Urgent Prior (Pre-Service) Authorization Procedures section, page 4, #1, and discussion of member request in writing or telephonic authorization request for provision of services.	
8.4.2.5	The MCO's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers; and	P/P for UM P/P for service authorization		Full	This requirement is addressed in 153.003 Standard and Urgent Prior (Pre-Service) Authorization Policy section, page 3.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
8.4.2.6	The MCO's service authorization system shall have capacity to electronically store and report the time and date all service authorization requests are received, decisions made by the MCO regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.	P/P for UM P/P for service authorization		Full	This requirement is addressed in 153.003 Standard and Urgent Prior (Pre-Service) Authorization Policy section, page 3.	
8.4.3	The MCO shall not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless the MCO can provide the service through an in-network or out-of-network provider for a lower level of care.	P/P for UM P/P for service authorization		Full	This requirement is addressed in 153.002 Concurrent Review, Policy section, page 3.	
8.4.4	Not later than July 1, 2018, the MCO shall utilize a common hospital observation policy that is developed and maintained collectively by MCO personnel with approval of LDH. The common hospital observation policy shall be reviewed annually by the MCOs in its entirety. Any revisions shall be reviewed and approved by LDH at least thirty (30) calendar days prior to implementation.	P/P prior authorization P/P for UM		Full	This requirement is addressed in Common Hospital Observation Policy Effective 7/1/2018, and track and trend of high-volume utilizers.	
8.4.5	The MCO shall perform prior authorization and concurrent utilization review for admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state or state mental hospitals.	P/P prior authorization P/P for UM		Full	This requirement is addressed in Common Hospital Observation Policy effective 7/1/2018 and examples given.	
8.4.5.1	The MCO shall ensure that inpatient psychiatric hospital and concurrent utilization reviews are completed by an LMHP for each enrollee referred for psychiatric admissions to general hospitals. The MCO shall comply with the requirements set forth in the Inpatient Psychiatric Services Rule [Louisiana Register, Vol. 21, No. 6, Page 575].	P/P for UM		Full	This requirement is addressed in 153.002 Concurrent Review, Policy section, page 4.	
8.4.5.2	Concurrent utilization reviews are administrative in nature and should not be reported to LDH in encounter data. These reviews are not considered prior authorizations because inpatient	P/P for UM		Full	This requirement is addressed in 153.002 Concurrent Review, Policy section, page 5.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	reimbursement is not edited against the utilization review prior to payment. Also, there are instances where individuals personally presenting at the inpatient psychiatric hospital may be admitted by hospital staff. However, LDH does reserve the right to recoup reimbursement when concurrent utilization reviews fail to document medical necessity for the inpatient psychiatric treatment.					
8.4.5.3	Concurrent utilization review includes: Provision of Emergency Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening for inpatient services following the sudden onset of severe psychiatric symptoms, which could reasonably be expected to make the individual harmful to self or others if not immediately under psychiatric treatment. The individual is in crisis and not currently in a place of safety. If the individual presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent, as the person needs to be seen right away to determine appropriate treatment. The referral from the MCO for an Emergency Inpatient Psychiatric Hospital Screen shall be made immediately. The screen to determine appropriate treatment shall be completed within one hour after request is received by an emergency room for post-stabilization treatment or three hours after receipt of the request in other circumstances. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, the procedures specified below should be utilized. Provision of an Urgent Inpatient Hospital	P/P for UM Evidence of timely submissions Notification communication to member/provider		Full	This requirement is addressed in the ACLA UM Program Description Delivery of UM Services section, page 6; UM 010L Timeliness of UM Decisions, Policy section, page 2; UM Timeliness Report and Analysis for Timeliness and Notification (3 reports: Q2, Q3, and Q4 2018). 8.4.5.3 -- BH IP Emergent Timeliness Report, BH IP Emergent Written Notification example, BH IP Urgent Written Notification example provided by the MCO. The MCO gave explanations of some issues noted in call center, such as high turnover, changes in system, and LDH requirements and responses and provided action plan to address above, such as cross training staff, rapid hiring of open FTEs.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	Psychiatric Screen: A concurrent utilization review screening is initiated if the individual meets one criterion specified on the state approved screening form and is currently in a place of safety. If the member presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent and follow the protocols and timeframes specified above. If the member presents at a hospital with a psychiatric unit or trained psychiatric personnel, and is admitted by the treating physician, then it will be classified as an urgent screen. The referral from the MCO for an Urgent Inpatient Psychiatric Hospital Screen shall be made within 24 hours after the referral and full medical information is received by MCO. The screen to determine appropriate treatment shall be completed within 24 hours of the MCO's referral after the referral and full medical information is received by MCO. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, due to concerns regarding the safety of a child/youth, the procedures specified above should be utilized. Upon completion of the Inpatient Psychiatric Hospital Concurrent Utilization Review, if the inpatient admission is approved, the MCO shall notify the provider and individual requesting the screen of the results in writing within 48 hours of receipt of the request by the MCO. If denied, the MCO shall notify the individual requesting the screen immediately, and within 48 hours of receipt of the request by the MCO provide written notification of the results to the provider and individual requesting the screen. The notification shall include whether or not an alternative					

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	community services plan is appropriate, the right of the member to appeal and the process to do so.					
8.4.6	Certification of Need (CON) for PRTFs					
8.4.6.1	The MCO shall comply with the requirements set forth at 42 CFR §441 Subpart D.					
8.4.6.2	The MCO shall ensure LMHPs are included in the team responsible for certification and recertification of PRTF services in Louisiana. This shall include a face-to-face assessment by an LMHP or a telephonic/video consultation with an LMHP who has had a face-to- face interview with the child/youth, in addition to the recommendations of a team specified at 42 CFR §441.154.	P/P Service utilization P/P Certification/recertification		Full	This requirement is addressed in UM.004L ACLA PRTF Authorization Process, page 2 #3(a)(v). **Recommendations:** The MCO should clarify that the role of the LMPH can only administratively deny and issue denial due to eligibility.	ACLA will update this policy accordingly.
8.4.6.3	The MCO may use an LMHP/team composed of the MCO's staff or the MCO may subcontract with an LMHP. To ensure the team has knowledge of the ambulatory resources available to the youth and the youth's situation, the MCO shall ensure that the team is assembled by a subcontract in the child's/youth's parish of residence or adjacent parish (if not in state custody) or the child's/youth's parish or adjacent parish of responsibility (if in state custody).	P/P for UM LMHP Subcontract		Full	This requirement is addressed in UM.004L ACLA PRTF Authorization Process, page 2 #3(a)(v).	
8.4.6.4	Recertifications shall occur every sixty (60) calendar days. For the PRTF screens to be complete, the team shall meet and rule out other community based options. This does not apply to other inpatient screens.	P/P certification		Full	This requirement is addressed in UM.004L ACLA PRTF Authorization Process, page 4 #7(a).	
8.4.6.5	In addition to certifying the need, the MCO shall: • Be responsible for tracking the member's authorization period for PRTF stays and providing notification to the responsible party when a recertification is due. • Ensure that PRTF certification, including the independent certification, are forwarded to the	P/P certification Tracking report P/P for UM Hospital reports		Full	This requirement is addressed in UM.004L ACLA PRTF Authorization Process, Procedure section, page 1 #2(d); page 3 #6(b-d); page 4 #6(7)(7a-c)(7e); PRTF Notification Tracking Report; PRTF Approval And Denial Notification examples/processes.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	admitting facility. ○ Upon completion of the screen, if the PRTF is approved, within 48 hours the MCO shall notify in writing the provider requesting the certification of the results, the member/guardian and, with member guardian consent, the referring party requesting the PRTF services on behalf of the youth. If approved, the MCO shall, in consultation with the member's guardian and referring party, locate a PRTF provider appropriate to meet the member's needs with availability to admit the member. ○ If denied, the MCO shall notify the provider requesting the certification immediately and within 48 hours provide written notification to the provider requesting the certification of the results, the member/guardian and, with the member/guardian consent, the referring party requesting the PRTF services on behalf of the youth. The notification shall include: information on alternative community services that may meet the member's needs to ensure health and safety, including information on available providers of those services, the right of the member to appeal, and the process to do so. For youth pending release from a secure setting for whom a PRTF is being requested, the MCO is required to coordinate the completion of the screen and the CON prior to the youth's release if it is anticipated that the youth will be re-linked to the MCO following release. ○ Generate a prior authorization for each PRTF admission within 48 hours of					

Utilization Management						
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	completion of the screen. ○ Accurately determine admissions and discharges to PRTFs and perform PRTF-specific eligibility functions. ○ Work with the Medicaid FI to determine retroactive eligibility and assignment, when applicable. ○ Maintain near real time bed utilization/availability and manage a waiting list for PRTF placement including out-of-state replacements.					
8.5	**Timing of Service Authorization Decisions**					
8.5.1	**Standard Service Authorization**					
8.5.1.1	The MCO shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination, with the exception of authorizations for CPST and PSR services for which the standard for determination is within five (5) calendar days of obtaining appropriate medical information. All standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.	P/P for UM P/P for standard service authorization		Full	This requirement is addressed in 153.010 Timeliness of UM Decisions, Policy Section, pages 1-3 (in grid); with the exception of community psychiatric support services (CPST) and psychosocial rehabilitative services (PSR), which are 5 days.	
8.5.1.1.1 8.5.1.1.1.1 8.5.1.1.1.2	The service authorization decision may be extended up to fourteen (14) additional calendar days if: • The member, or the provider, requests the extension; or • The MCO justifies (to LDH upon request) a need for additional information and how the extension is in the member's interest.			Full	This requirement is addressed in 153.010L Timeliness of UM Decisions, Policy section, pages 1-3 (in grid); ACLA 2018 UM Program Evaluation, page 9.	
8.5.1.2	The MCO shall make ninety-five percent (95%) of	P/P for UM		Full	This requirement is addressed in ACLA	

Utilization Management						
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	concurrent review determinations within one (1) business day and ninety-nine point five percent (99.5%) of concurrent review determinations within two (2) business days of obtaining the appropriate medical information that may be required.	P/P for concurrent review determinations			UM.010L Timeliness of UM Decisions Policy pages 1-3 (in grid); page 4, paragraphs 1-2; ACLA 2018 UM Program Evaluation, page 9.	
8.5.2	**Expedited Service Authorization**					
8.5.2.1	In the event a provider indicates, or the MCO determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.	P/P for UM P/P for expedited service authorization		Full	This requirement is addressed in 153.010 Timeliness of UM Decisions, Policy section, pages 1-3 (in grid); page 4, paragraphs 1-2; 2018 UM Program Evaluation, pages 9-15.	
8.5.2.2	The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if the MCO justifies to LDH a need for additional information and how the extension is in the member's best interest.	P/P for UM P/P for post authorization		Full	This requirement is addressed in ACLA UM.010L Timeliness of UM Decisions Policy, pages 1-3 (in grid); ACLA UM.003L Standard and Urgent Prior (Pre-Service) Authorization Procedure, page 6 #9; 2018 UM Program Evaluation, pages 9-15.	
8.5.3	**Post Authorization**					
8.5.3.1	The MCO shall make retrospective review determinations within thirty (30) days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred, eighty (180) days from the date of service.	P/P for UM P/P for post authorization		Full	This requirement is addressed in 153.200 Post Service Review, Policy section, page 1.	
8.5.3.2	The MCO shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a	P/P for UM P/P for post authorization		Full	This requirement is addressed in UM Program Description, page 19, paragraph 1.	

Utilization Management						
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	material omission or misrepresentation about the member's health condition made by the provider.					
8.5.4	**Timing of Notice**					
8.5.4.1	**Notice of Action**					
8.5.4.1.1	**Approval [Notice of Action]**					
8.5.4.1.1.1	For service authorization approval for a non-emergency admission, procedure or service, the MCO shall notify the provider verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	P/P for UM P/P for notice timing Includes UM File Review		Full	This requirement is addressed in 153.010 Timeliness of UM Decisions, Policy section, page 4. **BH/UM Denial File Review Results** Ten (10) files reviewed and 10 files compliant.	
8.5.4.1.1.2	For service authorization approval for extended stay or additional services, the MCO shall notify the provider rendering the service, whether a health care professional or facility or both, and the member receiving the service, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	P/P for UM P/P for notice timing		Full	This requirement is addressed in 153.010 Timeliness of UM Decisions, Policy section, page 4.	
8.5..4.1.2	**Adverse [Notice of Action]**					
8.5.4.1.2.1	The MCO shall notify the member, in writing using language that is easily understood by the member, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in Section 13 of this RFP. The notice of action to members shall be consistent with requirements in 42 CFR §438.404 and 42 CFR §438.210 and Section 12 of this RFP for member written materials.	P/P for UM P/P for notice timing Includes UM File Review		Full	This requirement is addressed in 153.017 Notice of Adverse Determination, Policy section, page 1.	

Utilization Management						
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8.5.4.1.2.2	The MCO shall notify the requesting provider of a decision to deny an authorization request or reauthorization or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested. The MCO shall notify the provider rendering the service, whether a health care professional or facility or both, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such written notification to the provider within two (2) business days of making the initial certification.	P/P for UM P/P for notice timing Includes UM File Review		Full	This requirement is addressed in 153.017 Notice of Adverse Determination, Policy section, page 2. **BH/UM Denial File Review Results** Ten (10) files reviewed and 10 files compliant.	
8.5.4.1.3	**Informal Reconsideration**					
8.5.4.1.3.1	As part of the MCO appeal procedures, the MCO should include an Informal Reconsideration process that allows the member (or provider/agent on behalf of a member) a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.	P/P for UM P/P for informal reconsideration		Full	This requirement is addressed in 153.105 Peer-to-Peer Discussion, page 1, and ACLA Denial Letter templates.	
8.5.4.1.3.2	In a case involving an initial determination or a concurrent review determination, the MCO should provide the member or a provider acting on behalf of the member and with the member's written consent an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination [(§438.402(b)(ii)].	P/P for UM P/P for informal reconsideration Includes UM File review		Full	This requirement is addressed in 153.105 Peer-to-Peer Discussion, page 1; Concurrent Review; ACLA Denial Letter templates; and ACLA Review Status Fax Forms. **BH/UM Denial File Review Results** Ten (10) files reviewed and 10 files compliant.	
8.5.4.1.3.3	The informal reconsideration should occur within one (1) working day of the receipt of the request and should be conducted between the provider rendering the service and the MCO's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse	P/P for UM P/P for informal reconsideration P/P for notice timing Includes Informal Consideration File Review		Full	This requirement is addressed in 153.105L Peer-to-Peer Discussion, Procedure section, page 3.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	determination cannot be available within one (1) working day.					
8.5.4.1.3.4	The Informal Reconsideration will in no way extend the thirty (30) day required timeframe for a Notice of Appeal Resolution.	P/P for UM P/P for informal reconsideration P/P for notice timing		Full	This requirement is addressed in 153.105L Peer-to-Peer Discussion, Procedure section, page 3.	
8.5.4.2	**Exceptions to Requirements**					
8.5.4.2	The MCO shall not require service authorization for emergency services or post-stabilization services as described in this Section whether provided by an in-network or out-of-network provider.	P/P for UM P/P for exceptions		Full	This requirement is addressed in 153.003L Standard and Urgent Prior Authorization, Attachment A, page 11.	
8.5.4.2	The MCO shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries	P/P for UM P/P for exceptions		Full	This requirement is addressed in 153.003L Standard and Urgent Prior Authorization, Attachment A, page 11.	
8.5.4.2	The MCO shall not require service authorization or referral for EPSDT screening services.	P/P for UM P/P for exceptions		Full	This requirement is addressed in 153.003L Standard and Urgent Prior Authorization, Attachment A, page 11.	
8.5.4.2	The MCO shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the MCO, regardless of whether such services are provided by an in-network or out-of-network provider, however, the MCO may require prior authorization of services beyond thirty (30) calendar days.	P/P for UM P/P for exceptions		Full	This requirement is addressed in 153.003L Standard and Urgent Prior Authorization, Attachment A, page 11.	
8.5.4.2	The MCO is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider for the first 30 days of a newly enrolled member's linkage to the plan.	P/P for UM P/P for exceptions		Full	This requirement is addressed in 153.706L Continuity of Care, Policy section, page 2 A#3.	
8.5.4.2	The MCO shall not require a PCP referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the MCO for routine and preventive women's	P/P for UM P/P for exceptions		Full	This requirement is addressed in ACLA UM.003L Standard and Urgent Prior (Pre-Service) Authorization, page 11, Attachment A.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	healthcare services and prenatal care.					
8.5.4.2	The MCO shall not require a PCP referral for in-network eye care and vision services.	P/P for UM P/P for exceptions		Full	This requirement is addressed in ACLA UM.003L Standard and Urgent Prior (Pre-Service) Authorization, page 11, Attachment A.	
8.5.4.2	The MCO may require notification by the provider of Obstetrical care at the time of the first visit of the pregnancy.	P/P for UM P/P for exceptions		Full	This requirement is addressed in ACLA UM.003L Standard and Urgent Prior (Pre-Service) Authorization, page 11, Attachment A.	
8.5.4.2	The MCO may require notification by the provider of Obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery and ninety-six (96) hours after caesarean section.	P/P for UM P/P for exceptions		Full	This requirement is addressed in ACLA UM.003L Standard and Urgent Prior (Pre-Service) Authorization, page 11, Attachment A.	
8.5.4.2	The MCO may require notification by the provider of inpatient emergency admissions within one (1) business day of admission.	P/P for UM P/P for exceptions		Full	This requirement is addressed in ACLA UM.003L Standard and Urgent Prior (Pre-Service) Authorization, page 11, Attachment A.	
8.11	**Medical History Information**					
8.11.1	The MCO is responsible for eliciting pertinent medical record information from the treating health care provider(s), as needed and/or as requested by LDH, for purposes of making medical necessity determinations.	P/P for UM		Full	This requirement is addressed in 153.003 Standard and Urgent Prior Authorization, Procedure section, pages 5 #7-8, and 153.008 Clinical Criteria, Procedure section, page 5 #2.	
8.11.2	The MCO shall take appropriate action when a treating health care provider does not cooperate with providing complete medical history information within the requested timeframe.	P/P for UM Provider Manual/Handbook Provider contracts		Full	This requirement is addressed in 153.003 Standard and Urgent Prior (Pre-Service) Authorization, pages 5-10, Procedure #8, and Service Agreements and tracking and trending providers.	
8.11.3	Providers who do not provide requested medical information for purposes of making medical necessity determinations, for a particular item or service, shall not be entitled to payment for the provision of such item or service.	P/P for UM Provider Manual/Handbook Provider contracts		Full	This requirement is addressed in AC: LA UM.003L Standard and Urgent Prior (Pre-Service) Authorization, pages 5-10, and Procedure #8, Service Agreements.	
8.11.4	Should a provider fail or refuse to respond to the MCO's request for medical record information, at the MCO's discretion or directive by LDH, the MCO	P/P for UM Provider Manual/Handbook Provider contracts		Full	This requirement is addressed in ACLA UM.003L Standard and Urgent Prior (Pre-Service) Authorization, pages 5-10,	

Utilization Management						
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	shall, at a minimum, impose financial penalties against the provider as appropriate.				Procedure #8, and Service Agreements.	
8.12	**PCP and Behavioral Health Provider Utilization and Quality Profiling**					
8.12.1	The MCO shall profile its PCPs and specialized behavioral health providers (including but not limited to addiction, mental health, and residential providers) and analyze utilization data to identify utilization and/or quality of care issues.	PCP/BN profiling report		Full	This requirement is addressed in AC:LA UM.003L Standard and Urgent Prior (Pre-Service) Authorization, page 1, Policy, and ACLA and UM.002L Concurrent Review, page 2, Policy, paragraph 3.	
8.12.2	The MCO shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.	P/P for UM		Full	This requirement is addressed in ACLA UM.003L Standard and Urgent Prior (Pre-Service) Authorization, page 1, Policy, and ACLA UM.002L Concurrent Review, page 2, Policy, paragraph 3.	
8.13	**Court-Ordered Assessment, Treatment, and Placement which Challenge Medical Necessity Determination and Defensible Lengths of Stay**					
8.13.1	All court-ordered Medicaid behavioral health services are subject to medical necessity review. In order to be eligible for payment, the service must be medically necessary and a covered benefit/service, as determined by the MCO within Louisiana Medicaid's medical necessity definition and are subject to medical necessity review.	Evidence of timely submission of profile reports		Full	This requirement is addressed in 153.003 Standard and Urgent Prior (Pre-Service) Authorization, Procedure section, pages 7-8 #20 and examples provided.	

Eligibility, Enrollment, and Disenrollment

Eligibility, Enrollment, and Disenrollment						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.56)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
11.11	**Disenrollment**					
11.11.1	Disenrollment is any action taken by LDH or its designee to remove a Medicaid MCO member from the MCO following the receipt and approval of a written request for disenrollment or a determination made by LDH or its designee that the member is no longer eligible for Medicaid or the Medicaid Managed Care Program.					
11.11.2	The Enrollment Broker shall be the single point of contact to the MCO member for notification of disenrollment.	P/P for Member Disenrollment		Full	This requirement is addressed in the Disenrollment and Enrollment Transition Policy on page 6.	
11.11.3	**Member Initiated Disenrollment**					
11.11.3.0	A member may request disenrollment from an MCO as follows:					
11.11.3.1	For cause, at any time. The following circumstances are cause for disenrollment: • The MCO does not, because of moral or religious objections, cover the service the member seeks; • The member needs related services to be performed at the same time, not all related services are available within the MCO and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk; • The contract between the MCO and LDH is terminated; • Poor quality of care; • Lack of access to MCO core benefits and services covered under the contract; • Documented lack of access within the MCO to providers experienced in dealing with the member's healthcare needs; • The member's active specialized behavioral health provider ceases to contract with the	P/P for Member Disenrollment		Full	This requirement is addressed in the Disenrollment and Enrollment Transition Policy on page 2, and the member handbook on page 38.	

Eligibility, Enrollment, and Disenrollment						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.56)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	MCO; • Member moves out of the MCO's service area, i.e. out of state; or • Any other reason deemed to be valid by LDH and/or its agent.					
11.11.3.2	Without cause for the following reasons: • During the ninety (90) day opt-out period following initial enrollment with the MCO for voluntary members; • During the ninety (90) days following the postmark date of the member's notification of enrollment with the MCO; • Once a year thereafter during the member's annual open enrollment period; • Upon automatic re-enrollment under 42 CFR §438.56(g), if a temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity; or • If LDH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a) (3).	P/P for Member Disenrollment		Full	This requirement is addressed in the Disenrollment and Enrollment Transition Policy on page 3.	
11.11.3.3	The member (or his/her representative) must submit an oral or written formal request to the Enrollment Broker for disenrollment.	P/P for Member Disenrollment		Full	This requirement is addressed in the Disenrollment and Enrollment Transition Policy on page 4.	
11.11.3.4	If the member's request for disenrollment is denied by the Enrollment Broker, the member can appeal directly to the State Fair Hearing process.	P/P for Member Disenrollment		Full	This requirement is addressed in the Disenrollment and Enrollment Transition Policy on page 4.	
11.11.4	**MCO Initiated Disenrollment**					
11.11.4.1	The MCO shall not request disenrollment because of a member's health diagnosis, adverse change in health status, utilization of medical services, diminished medical capacity, pre-existing medical condition, refusal of medical care or diagnostic testing, uncooperative or disruptive behavior resulting from him or her special needs, unless it seriously impairs the MCO's ability to furnish services to either this particular member or other	P/P for Member Disenrollment Member Notification Letter		Full	This requirement is addressed in the Disenrollment and Enrollment Transition Policy on page 2.	

Eligibility, Enrollment, and Disenrollment						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.56)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	MCO members, the member attempts to exercise his/her rights under the MCO's grievance system, or attempts to exercise his/her right to change, for cause, the primary care provider that he/she has chosen or been assigned. (42 CFR §438.56(b)(2)).					
11.11.4.2	The MCO shall not request disenrollment for reasons other than those stated in this RFP. (See Appendix U–**Guidelines for Involuntary Member Disenrollment**). In accordance with 42 CFR 438.56(b)(3), LDH will ensure that the MCO is not requesting disenrollment for other reasons by reviewing the mandatory MCO Disenrollment Request Forms submitted to the Enrollment Broker.	P/P for Member Disenrollment		Full	This requirement is addressed in the Disenrollment and Enrollment Transition Policy on page 2.	
11.11.4.3	The MCO may request involuntary disenrollment of a member if the member misuses or loans the member's MCO-issued ID card to another person to obtain services. In such case the MCO shall report the event to LDH;	P/P for Member Disenrollment		Full	This requirement is addressed in the Disenrollment and Enrollment Transition Policy on page 2.	
11.11.4.4	When the MCO request for involuntary disenrollment is approved by the Department, the MCO shall notify the member in writing of the requested disenrollment, the reason for the request, and the effective date.	P/P for Member Disenrollment Member Notification Letter		Full	This requirement is addressed in the Disenrollment and Enrollment Transition Policy on page 2.	
11.11.4.5	The MCO shall submit disenrollment requests to the Enrollment Broker which should include, at a minimum the member's name, ID number, detailed reasons for requesting the disenrollment, and a description of the measures taken to correct member behavior prior to requesting disenrollment, utilizing the **MCO Initiated Request for Member Disenrollment** form (See Appendix T).	P/P for Member Disenrollment		Full	This requirement is addressed in the Disenrollment and Enrollment Transition Policy on page 3.	
11.11.4.6	The MCO shall not submit a disenrollment request at such a date as would cause the disenrollment to be effective earlier than forty-five (45) calendar	P/P for Member Disenrollment		Full	This requirement is addressed in the Disenrollment and Enrollment Transition Policy on page 3.	

Eligibility, Enrollment, and Disenrollment						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.56)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	days after the occurrence of the event prompting the request for involuntary disenrollment. The MCO shall ensure that involuntary disenrollment documents are maintained in an identifiable member record.					
11.11.4.7	All requests will be reviewed on a case-by-case basis and are subject to the sole discretion of LDH or its designee (Enrollment Broker). All decisions are final and not subject to the dispute resolution process by the MCO.	P/P for Member Disenrollment		Full	This requirement is addressed in the Disenrollment and Enrollment Transition Policy on page 3.	
11.11.4.8	The Enrollment Broker will provide written notice of disenrollment to the member and request that the member choose a new MCO. The notice shall include a statement that if the member disagrees with the decision to disenroll the member from the MCO, the member has a right to file an appeal directly through the State Fair Hearing process.					
11.11.4.9	Until the member is disenrolled by the Enrollment Broker, the MCO shall continue to be responsible for the provision of all core benefits and services to the member.	P/P for Member Disenrollment		Full	This requirement is addressed in the Disenrollment and Enrollment Transition Policy on page 3.	

Marketing and Member Education

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

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	such fact must be disclosed in the marketing materials.	P/P for Disclosure of Financial Interest				
12.9.5	All written materials must be in accordance with the LDH "Person First" Policy, Appendix NN.	P/P for Written Member Materials Guidelines P/P for Compliance with "Person First" Policy Sample written member materials including Member Handbook		Full	This requirement is addressed in the Marketing and Member Materials Policy and in the member handbook.	
12.9.6	The quality of materials used for printed materials shall be, at a minimum, equal to the materials used for printed materials for the MCO's commercial plans if applicable.	P/P for Written Member Materials Guidelines Sample written member materials including Member Handbook		Not Applicable	The MCO does not have a commercial plan operating in Louisiana.	
12.9.7	The MCOs name, mailing address (and physical location, if different) and toll-free number must be prominently displayed on the cover of all multi-paged marketing materials.	P/P for Written Member Materials Guidelines Sample written member materials		Full	This requirement is addressed in the Marketing and Member Materials Policy. The MCO submitted the ACLA Spring/Summer 2018 Newsletter as evidence that the address and toll-free number are prominently displayed on member materials.	
12.9.8	All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services;	P/P for Written Member Materials Guidelines P/P for Informing Members/Potential Members of Interpretation Services		Full	This requirement is addressed in the Marketing and Member Materials Policy.	
12.9.9	All written materials related to MCO and PCP enrollment shall advise potential enrollees to verify with the medical services providers they prefer or have an existing relationship with, that such medical services providers are participating providers of the selected MCO and are available to serve the enrollee.	P/P for Written Member Materials Guidelines Sample written member materials including Member Handbook		Full	This requirement is addressed in the Marketing and Member Materials Policy.	
12.9.10	Alternative forms of communication must be provided upon request for persons with visual, hearing, speech, physical or developmental	P/P for Written Member Materials Guidelines P/P for Informing		Full	This requirement is addressed in the Marketing and Member Materials Policy.	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	disabilities. These alternatives must be provided at no expense to the member.	Members/Potential Members of Access to Alternative Forms of Communication				
12.9.15	Except as indicated, the MCO may develop their own materials that adhere to requirements set forth in this document or use state developed model member notices. State developed model notices must be used for denial notices and lock-in notices.					
12.11	**Member Education – Required Materials and Services**					
12.11	The MCO shall ensure all materials and services do not discriminate against Medicaid MCO members on the basis of their health history, health status or need for health care services. This applies to enrollment, re-enrollment or disenrollment materials and processes from the MCO.	P/P for Member Education P/P for Member Disenrollment P/P for Member Enrollment P/P for Member Re-enrollment		Full	This requirement is addressed in the Marketing and Member Materials Policy.	
12.11.3	**Member Materials and Programs for Current Enrollees**					
12.11.3.1	The MCO shall develop and distribute member educational materials, including, but not limited to, the following: A member-focused website which can be a designated section of the MCO's general informational website, and interactive media content such as a mobile device application, a mobile optimized website, or interactive social media;	Link to member portal		Full	This requirement is addressed through screenshots of the member portal, social media posts, and the MCO's mobile app.	
12.11.3.2	Bulletins or newsletters distributed not less than two (2) times a year that provide information on preventive care, access to PCPs and other providers and other information that is helpful to members;	Example of bullets/news letter		Full	This requirement is addressed in the ACLA Member Newsletters from 2018.	
12.11.3.3	Literature, including brochures and posters, such as calendars and growth charts, regarding all health or wellness promotion programs offered by	Brochures and other examples of literature including EPSTD materials		Full	This requirement is addressed in the 2018/2019 ACLA Care Card Brochure, the ACLA Bright Start Calendar, and the ACLA	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	the MCO's Medicaid Managed Care Plan. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders;				Appointment Reminder Card.	
12.11.3.4	Targeted brochures, posters and pamphlets to address issues associated with members with chronic diseases and/or special heath care needs;	Brochures and other examples targeted to members with chronic disease/SHCN		Full	This requirement is addressed in the ACLA Living Beyond Pain Flyer.	
12.11.3.5	Materials focused on health promotion programs available to the members;	Member education materials		Full	This requirement is addressed in the ACLA Roadmap to Health documentation.	
12.11.3.6	Communications detailing how members can take personal responsibility for their health and self-management;	Member handbook Member communications		Full	This requirement is addressed in the member handbook.	
12.11.3.7	Materials that promote the availability of health education classes for members;	Member handbook Member communications		Full	This requirement is addressed in the ACLA Wellness Center Calendar.	
12.11.3.8	Materials that provide education for members, with, or at risk for, a specific disability or illness;	Example Member education material		Full	This requirement is addressed in the ACLA I am a Healthy (Child) Asthma Flyer.	
12.11.3.9	Materials that provide education to members, members' families and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities;	Example Member education material		Full	This requirement is addressed in the ACLA Spring/Summer 2018 Member Newsletter, pages 4 and 5.	
12.11.3.11	Notification to its members of any change that LDH defines as significant at least thirty (30) calendar days before the intended effective date; and	Notification P/P member education		Full	This requirement is addressed in the member handbook.	
12.11.3.12	All materials distributed must comply with the relevant guidelines established by LDH for these materials and/or programs.	P/P member education		Full	This requirement is addressed in the member handbook.	
12.12	**MCO Member Handbook**					
12.12.1	The MCO shall develop and maintain separate member handbooks that adhere to the requirements in 42 CFR §438.10 (g) and may use the state developed model member handbook for each of the covered populations as specified in	Member Handbook		Full	This requirement is addressed in the member handbook and in the ACLA Behavioral Health Member Handbook.	

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

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
12.12.1.9	Procedures for obtaining benefits, including authorization requirements;	Member Handbook		Full	This requirement is addressed in the member handbook.	
12.12.1.10	Description on the purpose of the Medicaid card and the MCO card and why both are necessary and how to use them;	Member Handbook		Full	This requirement is addressed in the member handbook.	
12.12.1.11	The extent to which, and how, members may obtain benefits, including family planning services from out-of-network providers. An explanation shall be included that explains the MCO cannot require the enrollee to obtain a referral before choosing family planning provider;	Member Handbook		Full	This requirement is addressed in the member handbook.	
12.12.1.12	The extent to which, and how, after-hours, crisis and emergency coverage are provided, including: • What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR §438.114(a); • That prior authorization is not required for emergency services; • The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent; • The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered by the MCO; and • That, subject to the provisions of 42 CFR §438, the member has a right to use any hospital or other setting for emergency care.	Member Handbook		Full	This requirement is addressed in the member handbook.	
12.12.1.13	The post-stabilization care services rules set forth in 42 CFR 422.113(c);	Member Handbook		Full	This requirement is addressed in the member handbook.	
12.12.1.14	Policy on referrals for specialty care, including specialized behavioral health services and for other benefits not furnished by the member's PCP;	Member Handbook		Full	This requirement is addressed in the member handbook.	
12.12.1.15	How and where to access any benefits that are	Member Handbook		Full	This requirement is addressed in the	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	available under the Louisiana Medicaid State Plan but, are not covered under the MCO's contract with LDH;				member handbook.	
12.12.1.16	That the member has the right to refuse to undergo any medical service, diagnoses, or treatment or to accept any health service provided by the MCO if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds;	Member Handbook		Full	This requirement is addressed in the member handbook.	
12.12.1.17	For counseling or referral services that the MCO does not cover because of moral or religious objections, the MCO should direct the member to contact the Enrollment Broker for information on how or where to obtain the service;	Member Handbook		Full	This requirement is addressed in the member handbook.	
12.12.1.18	Member grievance, appeal and state fair hearing procedures and time frames, as described in 42 CFR §§438.400 through 438.424 and this RFP;	Member Handbook		Full	This requirement is addressed in the member handbook.	
12.12.1.19	Grievance, appeal and fair hearing procedures that include the following: • For State Fair Hearing: o The right to a hearing; o The method for obtaining a hearing; and o The rules that govern representation at the hearing; • The right to file grievances and appeals; • The requirements and timeframes for filing a grievance or appeal; • The availability of assistance in the filing process; • The toll-free numbers that the member can use to file a grievance or an appeal by phone; • The fact that, when requested by the member: o Benefits will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing; and	Member Handbook		Full	This requirement is addressed in the member handbook.	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	○ The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member. • In a State Fair Hearing, the Division of Administrative Law shall make the recommendation to the Secretary of the LDH who has final authority to determine whether services must be provided.					
12.12.1.20	Advance Directives, set forth in 42 CFR §438. 10 (g)(2) (xii) - A description of advance directives which shall include: • The MCO policies related to advance directives; • The member's rights under Louisiana state law, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives; any changes in law shall be reflected in the member handbook as soon as possible, but no later than ninety (90) calendar days after the effective date of the change; • Information that members can file complaints about the failure to comply with an advance directive with the Office of Health Standards, Louisiana's Survey and Certification agency) by calling 2253420138; and • Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.	Member Handbook		Full	This requirement is addressed in the member handbook.	
12.12.0.21	Information to call the Medicaid Customer Service Unit toll free hotline, go to Louisiana Medicaid website at www.medicaid.la.gov, or visit a regional Medicaid eligibility office to report if family size, living arrangements, parish of residence, or mailing address changes;	Member Handbook		Full	This requirement is addressed in the member handbook.	
12.12.1.22	How to make, change and cancel medical	Member Handbook		Full	This requirement is addressed in the	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	appointments and the importance of canceling and/or rescheduling rather than being a "no show";				member handbook.	
12.12.1.23	A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;	Member Handbook		Full	This requirement is addressed in the member handbook.	
12.12.1.24	How to obtain emergency and non-emergency medical transportation;	Member Handbook		Full	This requirement is addressed in the member handbook.	
12.12.1.25	Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	Member Handbook		Full	This requirement is addressed in the member handbook.	
12.12.1.26	Information about the requirement that a member shall notify the MCO immediately if he or she has a Workman's Compensation claim, a pending personal injury or medical malpractice law suit, or has been involved in an auto accident;	Member Handbook		Full	This requirement is addressed in the member handbook.	
12.12.1.27	Reporting requirements for the member that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported the MCO;	Member Handbook		Full	This requirement is addressed in the member handbook.	
12.12.1.28	Member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the MCO or LDH. This shall include a statement that the member is responsible for protecting their ID card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member's Medicaid eligibility and/or legal action;	Member Handbook		Full	This requirement is addressed in the member handbook.	
12.12.1.29	Instructions on how to request multi-lingual interpretation and translation when needed at no cost to the member. This instruction shall be included in all versions of the handbook in English and Spanish;	Member Handbook		Full	This requirement is addressed in the member handbook.	
12.121.30	Information on the member's right to a second opinion in accordance with 42 CFR §438.206(b)(3) at no cost and how to obtain it;	Member Handbook		Full	This requirement is addressed in the member handbook.	
12.12.1.31	Ways to report suspected provider fraud and	Member Handbook		Full	This requirement is addressed in the	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	abuse including but not limited to LDH and MCO toll-free numbers and website established for that purpose;				member handbook.	
12.12.1.32	Any additional text provided to the MCO by LDH or deemed essential by the MCO;	Member Handbook		Full	This requirement is addressed in the member handbook.	
12.12.1.33	The date of the last revision;	Member Handbook		Full	This requirement is addressed in the member handbook.	
12.12.1.34	Additional information that is available upon request, including the following: Information on the structure and operation of the MCO; Physician incentive plans [42 CFR 438.3 (i)]. Service utilization policies; and How to report alleged marketing violations to LDH utilizing the Marketing Complaint Form.	Member Handbook		Full	This requirement is addressed in the member handbook.	
12.12.1.35	Information regarding specialized behavioral health services, including but not limited to: • A description of covered behavioral health services; • Where and how to access behavioral health services and behavioral health providers; • General information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult engagement; resilience; strength-based and evidence-based practice; and best/proven practices; • Description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families; and • Any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment as per 42 CFR Part 2.	Member handbook		Full	This requirement is addressed in the member handbook.	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
12.12.1.36	Information on what to do if a member is billed, and under what circumstances a member may be billed for non-covered services;	Member handbook		Full	This requirement is addressed in the member handbook.	
12.12.1.37	The information specified in 12.12.1 et. seq. will be considered to be provided if the MCO:	Member handbook		Full	This requirement is addressed in the member handbook.	
12.12.1.37.1	Mails a printed copy of the information to the member's mailing address;			Full	This requirement is addressed in the member handbook.	
12.12.1.37.2	Provides the information by email after obtaining the member's agreement to receive the information by email;			Full	This requirement is addressed in the member handbook.	
12.12.1.37.3	Posts the information on their member website and advises the member in paper or electronic form that the information is available at the specified web address; or			Full	This requirement is addressed in the member handbook.	
12.12.1.37.4	Provides the information in any other method that can be reasonably expected to result in the member receiving the information.			Full	This requirement is addressed in the Member Handbook, member services and member newsletters.	
12.12.1.38	At least once a year, the MCO must notify the member of their option of receiving either the Member Handbook or the member Welcome Newsletter in either electronic format or hardcopy, upon request from the member.	Member notification		Full	This requirement is addressed in the ACLA Spring/Summer 2018 Newsletter.	
12.12.1.39	The MCO shall review and update the Member Handbook at least once a year. The Handbook must be submitted to LDH for approval within four weeks of the annual renewal, upon any changes, and prior to being made available to members.	Dated revision of member handbook		Full	This requirement is addressed in the member handbook and in the Marketing and Member Materials Policy.	
12.14	**Provider Directory for Members**					
12.14.1	The MCO shall develop and maintain a Provider Directory in four (4) formats:	P/P for Provider Directory Provider Directory		Full	This requirement is addressed in the Provider Adds Changes Load on pages 4 and 5.	
12.14.1.1	A hard copy directory, when requested, for members and potential members;	P/P for Provider Directory Provider Directory (hard copy)		Full	This requirement is addressed in the provider directory October 2018.	
12.14.1.2	Web-based searchable, web-based machine readable, online directory for members and the	P/P for Provider Directory Provider Directory (website		Substantial	This requirement is partially addressed in the provider directory.	ACLA is moving ahead with ensuring that the provider

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	public;	link)			The MCO does not yet have a machine readable online directory. <u>Recommendation:</u> It is recommended that the MCO work to make the online directory" machine readable". Post-onsite, the MCO stated that they are working to implement machine readability by creating a link to the JSON file (which is machine readable) within the Member component of the Website.	directory within the Member section of the website is machine readable. While we do not have an exact timeframe for implementation, we are moving forward as expeditiously as possible to make this happen.
12.14.1.3	Electronic file of the directory to be submitted and updated weekly to the Medicaid FI, the Enrollment Broker, or other designee as determined by LDH; for the Enrollment Broker; and	P/P for Provider Directory Provider Directory (electronic file format)		Full	This requirement is addressed in the New Provider/Practitioner Load /Data Update-Change Policy, page 5.	
12.14.1.4	Hard copy, abbreviated version upon request by the Enrollment Broker.	P/P for Provider Directory Provider Directory (abbreviated hard copy)		Full	This requirement is addressed in the New Provider/Practitioner Load /Data Update-Change Policy, page 5.	
12.14.3	The hard copy directory for members shall be reprinted with updates at monthly or no more than 30 days after the receipt of updated provider information. Inserts may be used to update the hard copy directories monthly to fulfill requests by members and potential members. The web-based online version shall be updated in real time, but no less than weekly. While daily updates are preferred, the MCO shall at a minimum submit no less than weekly. The abbreviated hard copy version for the Enrollment Broker will be available to all Medicaid enrollees when requested by contacting the Enrollment Broker. Format for this version will be in a format specified by LDH.	P/P for Provider Directory		Full	This requirement is addressed in the New Provider/Practitioner Load /Data Update-Change Policy, pages 4 and 5.	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
12.14.4	In accordance with 42 CFR 438.10(f) (6), the provider directory shall include, but not be limited to:					
12.14.4.1	Names, locations, telephone numbers of, website URLs, specialties, whether the provider is accepting new members, and cultural and linguistic capabilities by current contracted providers by each provider type specified in this RFP in the Medicaid enrollee's service area. Cultural and linguistic capabilities shall include languages offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competency training. The provider directory shall also indicate whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment;	P/P for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)		Substantial	This requirement is partially addressed in the New Provider/Practitioner Load/Data Update-Change Policy. Incorporation of whether a provider has completed cultural competency training is not found in the online provider directory <u>Recommendation:</u> The MCO should work to include whether a provider has completed cultural competency training in their provider directory. Post onsite, the MCO stated that they are working to load this information into FACETS, which captures information about providers. This will populate the online directory, which has this search functionality in the member portal, through the Advanced Search option.	This information is already being captured. However, ACLA is working to have this it populated in the online directory.
12.14.4.2	Identification of qualified providers divided into specific provider and service types and specializations, including but not limited to, primary care physicians, specialists, hospital PCP groups, clinic settings, home and community-based services, outpatient therapy, residential substance use, youth residential services, inpatient mental health and residential substance use services, and FQHCs and RHCs in the service area. This shall include a child serving list that is both monitored and frequently updated to ensure viable options are identified and available for OJJ, DCFS and LDOE field staff. The MCO provider types shall be delineated by parish and zip code;	P/P for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)		Full	This requirement is addressed in the New Provider/Practitioner Load /Data Update-Change Policy.	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
12.14.4.3	Identification of any restrictions on the enrollee's freedom of choice among network providers; and	P/P for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)		Full	This requirement is addressed in the provider directory and in New Provider/Practitioner Load /Data Update-Change Policy.	
12.14.4.4	Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours).	P/P for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)		Full	This requirement is addressed in the New Provider/Practitioner Load /Data Update-Change Policy.	
12.17.15	**Members' Rights and Responsibilities**					
12.17.15.1	The MCO shall have written policies regarding member rights and responsibilities. The MCO shall comply with all applicable state and federal laws pertaining to member rights and privacy. The MCO shall further ensure that the MCO's employees, contractors and MCO providers consider and respect those rights when providing services to members.	P/P for Member Rights and Responsibilities Member Handbook Provider Manual Provider Contract Contractor Contract		Full	This requirement is addressed in the Member Rights and Responsibilities, the provider handbook on pages 134 and 135, and in the LA Subcontractor Flowdown.	
12.15.2	Members Rights. The rights afforded to current members are detailed in Appendix AA, Members' Bill of Rights.	P/P for Member Rights and Responsibilities Member Handbook Provider Manual Provider Contract Contractor Contract		Full	This requirement is addressed in the Member Rights and Responsibilities and in the provider handbook on page 134.	
12.17.16	**Member Responsibilities**					
12.17.16.1	The MCO shall encourage each member to be responsible for his own health care by becoming an informed and active participant in their care. Members have the responsibility to cooperate fully with providers in following mutually acceptable courses of treatment, providing accurate medical and personal histories, and being present at scheduled appointments and reporting on treatment progress, such as notifying their health care provider promptly if serious side	P/P for Member Rights and Responsibilities Member Handbook Provider Manual Provider Contract Contractor Contract		Full	This requirement is addressed in the Member Rights and Responsibilities and in the provider handbook on page 135.	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	effects and complications occur, and/or worsening of the condition arises.					
12.17.16.2	The MCO members' responsibilities shall include but are not limited to: • Informing the MCO of the loss or theft of their ID card; • Presenting their MCO ID card when using health care services; • Being familiar with the MCO procedures to the best of the member's abilities; • Calling or contacting the MCO to obtain information and have questions answered; • Providing participating network providers with accurate and complete medical information; • Asking questions of providers to determine the potential risks, benefits and costs of treatment alternatives and following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible; • Living healthy lifestyles and avoiding behaviors know to be detrimental to their health; • Following the grievance process established by the MCO if they have a disagreement with a provider; and • Making every effort to keep any agreed upon appointments, and follow-up appointments; and accessing preventive care services, and contacting the provider in advance if unable to keep the appointment.	P/P for Member Rights and Responsibilities Member Handbook		Full	This requirement is addressed in the Member Rights and Responsibilities and in the member handbook on page 41.	
12.18	**Notice to Members of Provider Termination**					
12.18.1	The MCO shall make a good faith effort to give written notice of a provider's termination to each member who received their primary care from, or was seen on a regular basis by the terminated	P/P for Provider Termination P/P for notifying members of provider termination		Full	This requirement is addressed in the Notice to Members of Provider Termination.	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	provider. When timely notice from the provider is received, the notice to the member shall be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider.					
12.18.2	The MCO shall provide notice to a member or the parent/legal guardian and the involved state agency, as appropriate, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within seven (7) calendar days from the date the MCO becomes aware of such, if it is prior to the change occurring. Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the MCO becoming aware of the circumstances.	P/P for Provider Termination P/P for notifying members of provider termination		Full	This requirement is addressed in the Notice to Members of Provider Termination.	
12.19	**Oral Interpretation and Written Translation Services**					
12.19.1	In accordance with 42 CFR §438.10(d) LDH shall provide on its website the prevalent non-English language spoken by enrollees in the state.					
12.19.2	The MCO must make real-time oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages not just those that Louisiana specifically requires (Spanish). The enrollee is not to be charged for interpretation services. The MCO must notify its enrollees that oral	P/P for oral and written interpretation services P/P for notification of member of interpretation services and how to access the services		Full	This requirement is addressed in the Contact Center Scope-Member Services documentation.	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	interpretation is available for any language and how to access those services. On materials where this information is provided, the notation should be written in Spanish.					
12.19.3	The MCO shall ensure that translation services are provided for all written marketing and member education materials for any language that is spoken as a primary language for four percent (4%) or more enrollee or potential enrollees of an MCO. Within ninety (90) calendar days of notice from LDH, materials must be translated and made available. Materials must be made available at no charge in that specific language to assure a reasonable chance for all members to understand how to access the MCO and use services appropriately as specified in 42 CFR §438.10(c) (4) and (5).	P/P for oral and written interpretation services P/P for notification of member of interpretation services and how to access the services		Full	This requirement is addressed in the Marketing and Member Materials Policy, page 5, and in the Notification of Member Language Services Policy, pages 13, 14, and 21.	
12.19.4	Written materials must also be made available in alternative formats upon request of the potential member or member at no cost. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost. Written materials must include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the MCO's member/customer service unit. Large print means printed in a font size no smaller than 18 point.	P/P for Member Rights and Responsibilities		Full	This requirement is addressed in the Marketing and Member Materials Policy.	

Member Grievance and Appeals

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
13.0	**Member Grievance and Appeals Procedures**					
13.2	**General Grievance System Requirements**					
13.2.1	Grievance System. The MCO must have a system in place for members that include a grievance process, an appeal process, and access to the State Fair Hearing system, once the MCO's appeal process has been exhausted. The MCO shall permit a member to file a grievance and request an MCO level appeal subject only to the limitations expressly provided in this Section. A member shall be permitted to request a State Fair Hearing after receiving notice that the action is upheld or once the MCO's appeals process has been exhausted.	P/P for Grievances P/P for Appeals P/P for Fair Hearing		Full	This requirement is addressed in the Member Grievances Policy, page 1, and in the Appeals Policy, page 6.	
13.2.2	**Filing Requirements**					
13.2.2.1	**Authority to File**					
13.2.2.1.1	A member, or authorized representative acting on the member's behalf, may file a grievance and an MCO level appeal, and may request a State Fair Hearing, once the MCO's appeals process has been exhausted.	P/P for Grievances P/P for Appeals P/P for Fair Hearing		Full	This requirement is addressed in the Member Grievances Policy, page 4, and in the Appeals Policy, page 6.	
13.2.2.1.2	A network provider, acting on behalf of the member and with the member's written consent, may file an appeal. A network provider may file a grievance or request a State Fair Hearing on behalf of a member.	P/P for Grievances P/P for Appeals P/P for Fair Hearing		Full	This requirement is addressed in the Member Grievances Policy, page 4, and in the Appeals Policy, page 6.	
13.2.3	**Time Limits for Filing** The member shall be permitted to file a grievance at any time. The member must be allowed sixty (60) calendar days from the date on the MCO's notice of action or inaction to request an appeal.	P/P for Grievances P/P for Appeals P/P for Fair Hearing		Full	This requirement is addressed in the Member Grievances Policy, page 4 and in the Appeals Policy, page 6.	
13.2.4 13.2.4.1	**Procedures for Filing** The member may file a grievance orally or in	P/P for Grievances		Full	This requirement is addressed in the Member Grievances Policy, page 8.	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	writing with either LDH or the MCO.					
13.2.4.2	The member or provider may file an appeal either orally or in writing. The oral appeal shall be followed by a written, signed appeal unless the member requests an expedited resolution.	P/P for Appeals P/P for Fair Hearing		Full	This requirement is addressed in the Appeals Policy, page 6.	
13.2.4.3	The MCO shall ensure that all MCO members are informed of the State Fair Hearing process and of the MCO's grievance and appeal procedures. The MCO shall provide to each member a member handbook that shall include descriptions of the MCO's grievance and appeal procedures. Forms on which members may file grievances, appeals, concerns or recommendations to the MCO shall be available through the MCO, and paper copies must be provided by the MCO upon request of the member. The MCO shall make all forms easily available on the MCO's website.	P/P for Grievances P/P for Appeals P/P for Fair Hearing		Full	This requirement is addressed in the Member Grievances Policy, page 9, and in the Appeals Policy, page 5.	
13.3	**Grievance/Appeal Records and Report**					
13.3.1	The MCO must maintain accurate records of all grievances and appeals in a manner accessible to LDH and available upon request to CMS. A copy of grievances logs and records of disposition of appeals shall be retained for ten (10) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the ten (10) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular ten (10) year period, whichever is later.	P/P for Grievances P/P for Appeals		Full	This requirement is addressed in the Member Grievances Policy, page 10, and in the Appeals Policy, page 2.	
13.3.2	The MCO shall electronically maintain data on grievances/appeals in accordance with the requirements outlined in this section, to include, but not be limited to: member's name and Medicaid number, summary of grievances and appeals; date of filing; current status; date of	P/P for monthly reporting of grievances and appeals including sample report format		Full	This requirement is addressed in the Member Grievances Policy, page 9, and in the Appeals Policy, page 3.	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	review or review meeting; resolution information for each level of grievance or appeal, if applicable; date of resolution at each level, if applicable; date of review or review meeting; resolution information for each level of grievance or appeal, if applicable; date of resolution at each level, if applicable; and resulting corrective action.					
13.3.3	The MCO will be responsible for promptly forwarding any adverse decisions to DHH for further review/action upon request by DHH or the MCO member. DHH may submit recommendations to the MCO regarding the merits or suggested resolution of any grievance/appeal.	P/P for Adverse Decisions		Full	This requirement is addressed in the Appeals Policy, page 3.	
13.4	**Handling of Grievances and Appeals**					
13.4.1	**General Requirements** In handling grievances and appeals, the MCO must meet the following requirements:					
13.4.1.1	Acknowledge receipt of each grievance and appeal in writing within five (5) business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the monthly grievance log;	P/P for Grievances P/P for Appeals Acknowledgement Letter Template Includes Member Grievance File Review		Full	This requirement is addressed in the Member Grievances Policy, page 5, and in the Appeals Policy, page 7.	
13.4.1.2	Give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability;	P/P for Grievances P/P for Appeals		Full	This requirement is addressed in the Member Grievances Policy, page 9, and in the Appeals Policy, page 5.	
13.4.1.3 13.4.1.3.1 13.4.1.3.2 13.4.1.3.3	Ensure that the individuals who make decisions on grievances and appeals are individuals: • who were not involved in any previous level of review or decision-making; nor a subordinate of any such individual;	P/P for Grievances P/P for Appeals Includes Member Grievance File Review		Full	This requirement is addressed in the Member Grievances Policy, page 9, and in the Appeals Policy, page 7. **Grievance File Review Results**	

Member Grievances and Appeals						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	• who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by LDH, in treating the member's condition or disease: ○ an appeal of a denial that is based on lack of medical necessity, ○ a grievance regarding denial of expedited resolution of an appeal, ○ a grievance or appeal that involves clinical issues. • Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial action.				Fifteen (15) of 15 grievance files reviewed were compliant. **Appeals File Review Results** Ten (10) of 10 appeals files reviewed were compliant.	
13.4.2	**Special Requirements for Appeals** The process for appeals must:					
13.4.2.1	Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal). The member, member's authorized representative or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. Unless the member requests an expedited appeal, the oral appeal shall be confirmed in writing.	P/P for Appeals Member Handbook Confirmation Letter Template		Full	This requirement is addressed in the Appeals Policy, pages 11 and 12, and in the member handbook, page 45.	
13.4.2.2	Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO must inform the member of the limited time available for this sufficiently in advance of the date by which the MCO shall resolve the appeal in the case of expedited resolution).	P/P for Appeals Member Handbook Process for notifying member of opportunity to provide evidence Includes Member Appeal File Review		Full	This requirement is addressed in the Appeals Policy, page 8, and in the member handbook, page 45. **Appeals File Review Results** Ten (10) of 10 appeals files reviewed were compliant.	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
13.4.2.3	Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process and any evidence considered, relied upon, or generated by the MCO in connection with the appeal. This information shall be provided free of charge and sufficiently in advance of the date by which the MCO shall resolve the appeal.	P/P for Appeals Member Handbook Process for notifying member of opportunity to examine case file Includes Member Grievance File Review		Full	This requirement is addressed in the Appeals Policy, page 6, and in the member handbook, page 45. **Grievance File Review Results** Fifteen (15) of 15 grievance files reviewed were compliant.	.
13.4.2.4	Include, as parties to the appeal: the member and his or her representative; or the legal representative of a deceased member's estate.	P/P for Appeals Member Handbook Includes Member Appeals File Review		Full	This requirement is addressed in the Appeals Policy, page 8. **Appeals File Review Results** Ten (10) of 10 appeals files reviewed were compliant.	
13.4.3	**Training of MCO Staff** The MCO's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and providers.	Training Agendas and attachments Sign-in sheets		Full	This requirement is addressed in the Grievance Team Meeting Agenda and Sign-in Sheet, the Appeals Coordinator Training Manual, the Appeals Training Manual for Nursing, and in the Expedited Appeals Process. Additionally, the MCO submitted meeting minutes and agendas as evidence of compliance with this requirement.	
13.4.4	**Identification of Appropriate Party** The appropriate individual or body within the MCO having decision making authority as part of the grievance/appeal procedure shall be identified.	Name and title of individual or name of body having decision-making authority Job description for individual having decision-making authority		Full	This requirement is addressed in the Appeals Policy, page 8.	
13.4.5	**Failure to Make a Timely Decision** Appeals shall be resolved no later than stated time frames and all parties shall be informed of the MCO's decision. If a determination is not made in accordance with the timeframes specified, the	P/P for Appeals		Full	This requirement is addressed in the Appeals Policy, page 9.	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	member's request will be deemed to exhaust the MCO's appeal process as of the date upon which a final determination should have been made. The member may then initiate a State Fair Hearing.					
13.4.6	**Right to State Fair Hearing** The MCO shall inform the member of their right to seek a State Fair Hearing if the member is not satisfied with the MCO's decision in response to an appeal and the process for doing so.	P/P for Appeals P/P for Fair Hearing Appeal Resolution Notice		Full	This requirement is addressed in the Appeals Policy, page 2.	
13.5	**Notice of Action**					
13.5.1	**Language and Format Requirements** The notice must be in writing and must meet the language and format requirements of 42 C.F.R. §438.10 and Section 12 of this RFP to ensure ease of understanding.	Notice of Action Includes Member Grievance and Appeal File Review		Full	This requirement is addressed in the Notice of Adverse Determination, pages 3 and 4, and in the UM Denial Letter. **Grievance File Review Results** Fifteen (15) of 15 grievance files reviewed were compliant. **Appeals File Review Results** Ten (10) of 10 appeals files reviewed were compliant.	
13.5.2	**Content of Notice of Action** The Notice of Action must explain the following:					
13.5.2.1	The action the MCO or its contractor has taken or intends to take;	P/P for Notice of Action Notice of Action Includes Member Grievance and Appeal File Review		Full	This requirement is addressed in the Notice of Adverse Determination, pages 3 and 4, and in the UM Denial Letter. **Grievance File Review Results** Fifteen (15) of 15 grievance files reviewed were compliant. **Appeals File Review Results** Ten (10) of 10 appeals files reviewed were compliant.	
13.5.2.2	The reasons for the action; including the right of the member to be provided upon request and free	P/P for Notice of Action Notice of Action		Full	This requirement is addressed in the Notice of Adverse Determination, pages 3 and 4,	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;	Includes Member Appeal File Review			and in the UM Denial Letter. **Appeals File Review Results** Ten (10) of 10 appeals files reviewed were compliant.	
13.5.2.3	The member's right to file an appeal with the MCO;	P/P for Notice of Action Notice of Action		Full	This requirement is addressed in the Notice of Adverse Determination, pages 3 and 4, and in the UM Denial Letter.	
13.5.2.4	The member's right to request a State Fair Hearing, after the MCO's appeal process has been exhausted;	P/P for Notice of Action Notice of Action Includes Member Appeal File Review		Full	This requirement is addressed in the Notice of Adverse Determination, pages 3 and 4, and in the UM Denial Letter. **Appeals File Review Results** Ten (10) of 10 appeals files reviewed were compliant.	
13.5.2.5	The procedures for exercising the rights specified in this section;	P/P for Notice of Action Notice of Action		Full	This requirement is addressed in the Notice of Adverse Determination, pages 3 and 4, and in the UM Denial Letter.	
13.5.2.6	The circumstances under which expedited appeal is available and how to request it;	P/P for Notice of Action Notice of Action		Full	This requirement is addressed in the Notice of Adverse Determination, pages 3 and 4, and in the UM Denial Letter.	
13.5.2.7	The member's right to have benefits continued pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services; and	P/P for Notice of Action Notice of Action Includes Member Grievance File Review		Full	This requirement is addressed in the Notice of Adverse Determination, pages 3 and 4, and in the UM Denial Letter. **Grievance File Review Results** Fifteen (15) of 15 grievance files reviewed were compliant.	
13.5.2.8	Availability of interpretation services for all languages and how to access them.	P/P for Notice of Action Notice of Action		Full	This requirement is addressed in the Notice of Adverse Determination, pages 3 and 4,	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					and in the UM Denial Letter.	
13.5.3	**Timing of Notice of Action** The MCO must mail the Notice of Action within the following timeframes:					
13.5.3.1	For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before the date of action,:	P/P for Notice of Action		Full	This requirement is addressed in the Notice of Adverse Determination, pages 3 and 4, and in the UM Denial Letter.	
13.5.3.2	In cases of verified member fraud, or when LDH has facts indicating that action should be taken because of probable member fraud at least five (5) days before the date of action;	P/P for Notice of Action		Full	This requirement is addressed in the Notice of Adverse Determination, pages 3 and 4, and in the UM Denial Letter.	
13.5.3.3	By the date of action for the following: • In the death of a recipient; • If the member submits a signed written recipient statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information); • The recipient's admission to an institution where he is eligible for further services; • The recipient's address is unknown and mail directed to him has no forwarding address; • The recipient has been accepted for Medicaid services by another local jurisdiction; or • The recipient's physician prescribes the change in the level of medical care; or • As otherwise permitted under 42 CFR §431.213.	P/P for Notice of Action		Full	This requirement is addressed in the Notice of Adverse Determination, pages 3 and 4, and in the UM Denial Letter.	
13.5.3.4	For denial of payment, at the time of any action affecting the claim according to the terms and conditions outlined in the contract between the provider and the individual MCO.	P/P for Notice of Action		Full	This requirement is addressed in the Timeliness of UM Decision Policy, page 1, and in the Notice of Adverse Determination, page 4.	
13.5.3.5 13.5.3.5.1	For standard service authorization decisions that deny or limit services, as expeditiously as the	P/P for Notice of Action P/P for Notice of Action for		Full	This requirement is addressed in the Timeliness of UM Decision grid, page 2, and	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
13.5.3.5.2	member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if: • The member, or the provider, acting on behalf of the member and with the member's written consent, requests extension; or • The MCO justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	Standard Service Authorizations P/P for Handling Extensions Notice of Decision to Extend Timeframe			in the Standard and Urgent Prior (Pre-Service) Authorization, page 6.	
13.5.3.6	If the MCO extends the timeframe in accordance with above, it must: • Make reasonable efforts to give the member prompt oral notice of the delay; • Within two (2) days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision, and • Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.	P/P for Notice of Action P/P for Handling Extensions Notice of Decision to Extend Timeframe		Full	This requirement is addressed in the Timeliness of UM Decision Policy, page 4, the Standard and Urgent Prior (Pre-Service) Authorization, page 3, and in the Appeals Policy, page 9.	
13.5.3.7	On the date the timeframe for service authorization as specified expires. Untimely service authorizations constitute a denial and are thus adverse actions.	P/P for Notice of Action		Full	This requirement is addressed in the Timeliness of UM Decision Policy, page 2.	
13.5.3.8	For expedited service authorization decisions where a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later	P/P for Notice of Action P/P for Notice of Action for Expedited Service Authorizations		Full	This requirement is addressed in the Timeliness of UM Decision Policy, page 1, and in the Standard and Urgent Prior (Pre-Service) Authorization, page 4.	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	than seventy-two (72) hours after receipt of the request for service.					
13.5.3.9	The MCO may extend the seventy-two (72) hours time period by up to fourteen (14) calendar days if the member requests an extension, or if the MCO justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	P/P for Notice of Action P/P for Handling Extensions Notice of Decision to Extend Timeframe		Full	This requirement is addressed in the Timeliness of UM Decision Policy, page 1, and in the Standard and Urgent Prior (Pre-Service) Authorization, page 6.	
13.5.3.10	DHH will conduct random reviews to ensure that members are receiving such notices in a timely manner.					
13.6	**Resolution and Notification**					
13.6	The MCO must dispose of a grievance and resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within the timeframes established below.	P/P for Grievances P/P for Appeals		Full	This requirement is addressed in the Member Grievances Policy, page 9, and in the Appeals Policy, page 8.	
13.6.1	**Specific Timeframes**					
13.6.1.1	**Standard Disposition of Grievances** For standard disposition of a grievance and notice to the affected parties, the timeframe is established as ninety (90) days from the day the MCO receives the grievance.	P/P for Grievances		Full	This requirement is addressed in the Member Grievances Policy, page 9.	
13.6.1.2	**Standard Resolution of Appeals** For standard resolution of an appeal and notice to the affected parties, the timeframe is established as thirty (30) calendar days from the day the MCO receives the appeal. This timeframe may be extended under Section 13.6.1.2 of this Section.	P/P for Appeals Includes Member Appeals File Review		Full	This requirement is addressed in the Appeals Policy, page 9. **Appeals File Review Results** Ten (10) of 10 appeals files reviewed were compliant.	
13.6.1.3	**Expedited Resolution of Appeals** For expedited resolution of an appeal and notice to affected parties, the timeframe is established as seventy-two (72) hours after the MCO receives the appeal. This timeframe may be extended under Section 13.6.2 of this Section.	P/P for Appeals Includes Member Appeal File Review		Full	This requirement is addressed in the Appeals Policy, page 9. **Appeals File Review Results** Two (2) of 2 expedited case appeals files reviewed were compliant.	
13.6.2.1	**Extension of Timeframes** The MCO may extend the timeframes from	P/P for Appeals P/P for Grievances		Full	This requirement is addressed in the Member Grievances Policy, page 10, and in	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	Section 13.6.1 of this Section by up to fourteen (14) calendar days if: • The member requests the extension; or • The MCO shows (to the satisfaction of DHH, upon its request) that there is need for additional information and how the delay is in the member's interest.	P/P for Handling Extensions Notice of Decision to Extend Timeframe Includes Member Appeal File Review			the Appeals Policy, page 9. **Appeals File Review Results** Ten (10) of 10 appeals files reviewed were compliant.	
13.6.2.2	**Requirements Following Timeframe Extension** If the MCO extends the timeframes, it must, for any extension not requested by the member: • Give the member written notice of the reason for the delay. • Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.	P/P for Appeals P/P for Grievances P/P for Handling Extensions Notice of Decision to Extend Timeframe Includes member Appeal File Review		Full	This requirement is addressed in the Appeals Policy, page 9. **Appeals File Review Results** Ten (10) of 10 appeals files reviewed were compliant.	
13.6.3	In the case of an MCO that fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's appeal process and may initiate a state fair hearing.	P/P for Appeals		Full	This requirement is addressed in the Appeals Policy, page 9.	
13.6.4 13.6.4.1 13.6.4.2	**Format of Notice of Disposition** **Grievances.** The MCO will provide written notice to the member of the disposition of a grievance. **Appeals.** For all appeals, the MCO must provide written notice of disposition. For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice.	P/P for Grievances P/P for Appeals Resolution Notice		Full	This requirement is addressed in the Member Grievances Policy, page 10, and in the Appeals Policy, page 9.	
13.6.5 13.6.5.1 13.6.5.2	**Content of Notice of Appeal Resolution** The written notice of the resolution must include the following: the results of the resolution process	P/P for Appeals Resolution Notice		Full	This requirement is addressed in the Appeals Policy, pages 9 and 10.	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	and the date it was completed. For appeals not resolved wholly in favor of the members: the right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action.					
13.6.6	**Requirements for State Fair Hearings** The MCO shall comply with all requirements as outlined in this RFP.					
13.6.6.1	**Availability.** If the member has exhausted the MCO-level appeal procedures, the member may request a State Fair Hearing within one hundred twenty (120) days from the date of the MCO's notice of resolution. The member may also initiate a State Fair Hearing following deemed exhaustion of appeals processes.	P/P for Appeals P/P for Fair Hearings		Full	This requirement is addressed in the Appeals Policy, page 10.	
13.6.6.2	**Parties.** The parties to the State Fair Hearing include the MCO as well as the member and his or her representative or the representative of a deceased member's estate.	P/P for Fair Hearings		Full	This requirement is addressed in the Appeals Policy, page 8.	
13.7	**Expedited Resolution of Appeals**					
13.7.0	The MCO must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the member) or the provider, acting on behalf of the member and with the member's written consent, indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.	P/P for Appeals		Full	This requirement is addressed in the Appeals Policy, page 4.	
13.7.1	**Prohibition Against Punitive Action** The MCO must ensure that punitive action is not	P/P for Appeals Provider Handbook		Full	This requirement is addressed in the Appeals Policy, page 9, and in the provider handbook,	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	taken against a provider, acting on behalf of the member and with the member's written consent, who requests an expedited resolution or supports a member's appeal.				page 139.	
13.7.2	**Action Following Denial of a Request for Expedited Resolution** If the MCO denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the timeframe for standard resolution; • Make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice. • This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an Action or require a Notice of Action. The Member may file a grievance in response to this decision.	P/P for Appeals Denial Notice		Full	This requirement is addressed in the Appeals Policy, page 7.	
13.7.3	**Failure to Make a Timely Decision** Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the MCO's decision in writing. If a determination is not made by the above timeframes, the member's request will be deemed to have exhausted the MCO's appeal process as of the date upon which a final determination should have been made.	P/P for Appeals		Full	This requirement is addressed in the Appeals Policy, page 9.	
13.7.4 13.7.4.1	**Process** The MCO is required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution. The member or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in	P/P for Appeals		Full	This requirement is addressed in the Appeals Policy, page 1.	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	writing. No additional follow-up may be required.					
13.7.4.2	The MCO shall inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.	Process for notifying member of opportunity to present evidence		Full	This requirement is addressed in the Appeals Policy, page 5 and in the UM Denial Letter.	
13.7.5	**Authority to File** The Medicaid member or their provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional member follow-up is required.	P/P for Appeals		Full	This requirement is addressed in the Appeals Policy, page 6.	
13.7.6	**Format of Resolution Notice** In addition to written notice, the MCO must also make reasonable effort to provide oral notice.	P/P for Appeals Includes Member Appeal File Review		Full	This requirement is addressed in the Appeals Policy, page 7. **Appeals File Review Results** Ten (10) of 10 appeals files reviewed were compliant.	
13.8	**Continuation of Benefits**					
13.8.1	Terminology - As used in this section, "timely" filing means filing on or before the later of the following: within ten (10) days of the MCO mailing the notice of action or the intended effective date of the MCO's proposed action.					
13.8.2	**Continuation of Benefits** The MCO must continue the member's benefits if: The member or the provider, acting on behalf of the member and with the member's written consent, files the appeal timely in accordance with 42 CFR §438.402(c)(1)(ii) and (c)(2)(ii); • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; • The services were ordered by an authorized provider; • The original period covered by the original authorization has not expired; and	P/P for Continuation of Benefits Process for notifying member of continuation of benefits		Full	This requirement is addressed in the Appeals Policy, page 10.	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	• The member requests extension of benefits.					
13.8.3	**Duration of Continued or Reinstated Benefits** If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs: • The member withdraws the appeal; • Ten (10) days pass after the MCO mails the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10) day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached; • A State Fair Hearing Officer issues a hearing decision adverse to the member; • The time period or service limits of a previously authorized service has been met.	P/P for Continuation of Benefits Process for notifying member of continuation of benefits		Full	This requirement is addressed in the Appeals Policy, page 10.	
13.8.4	**Member Responsibility for Services Furnished While the Appeal is Pending** If the final resolution of the appeal is adverse to the member, that is, upholds the MCO's action, the MCO may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this Section, and in accordance with the policy set forth in 42 C.F.R. § 431.230(b).	P/P for Continuation of Benefits Process for notifying member of continuation of benefits		Full	This requirement is addressed in the Appeals Policy, page 11.	
13.9	**Information to Providers and Contractors**					
13.9.0	The MCO must provide the information specified at 42 C.F.R. § 438.10(g)(2)(xi) about the grievance system to all providers and contractors at the time they enter into a contract.	Provider Manual/Handbook Provider Contract Contractor Contract		Full	This requirement is addressed in the provider handbook, page 137.	
13.10	**Recordkeeping and Reporting Requirements**					
13.10.0	Reports of grievances and resolutions shall be submitted to DHH as specified in Section 13.4 and of this RFP. The MCO shall not modify the grievance procedure without the prior written	P/P for Grievances P/P for reporting grievances and resolutions to DHH		Full	This requirement is addressed in the Member Grievances Policy, page 9.	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	approval of DHH.	Report Format				
13.11	**Effectuation of Reversed Appeal Resolutions**					
13.11.1	**Services not Furnished While the Appeal is Pending** If the MCO or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the decision..	P&P for effectuation of reversed appeal resolutions		Full	This requirement is addressed in the Appeals Policy, page 11.	
13.11.2	**Services Furnished While the Appeal is Pending** If the MCO or the State Fair Hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO must pay for those services, in accordance with this Contract.	P&P for effectuation of reversed appeal resolutions		Full	This requirement is addressed in the Appeals Policy, page 11.	

Quality Management

Quality Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
14.1	**Quality Assessment and Performance Improvement Program (QAPI)**					
14.1.1	The MCO shall establish and implement a Quality Assessment and Performance Improvement (QAPI) program, as required by 42 CFR §438.330(a)(1), to:					
14.1.1.2	Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities;	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the ACLA Program Description on page 10.	
14.1.3	Incorporate improvement strategies that include, but are not limited to: performance improvement projects; medical record audits; performance measures; Plan-Do-Study-Act cycles or continuous quality improvement activities; member and/or provider surveys; and activities that address health disparities identified through data collection.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the ACLA Program Description on page 41. ACLA participates in the two required PIPs that address health disparities. ACLA conducted CAHPs and a provider survey.	
14.1.4	Detect and address underutilization and overutilization of services	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the ACLA Program Description on page 13. UM issues are discussed in the Quality Committee meetings. QCC Meeting minutes were reviewed on-site, where utilization was discussed.	
14.1.6	The MCO shall establish a quality improvement strategy which includes at least three (3) non-medically indicated procedures for either prior authorization or nonpayment in specific populations. Multiple medical specialty recommendations on appropriate utilization of services can be found at www.choosingwisely.org/. The strategy will be reviewed and approved by LDH prior to initial	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the Master NIA Clinical Guidelines –CT, MRI Brain and MRI Thoracic Spine. This requirement is also addressed in several recommendations outlined in Choosing Wisely. The strategy was reviewed and approved by	

Quality Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	implementation and prior to implementation of significant changes, defined as adding or deleting a procedure, to the strategy.				LDH after the review period.	
14.1.7	The MCO shall reduce underutilization of services in areas including, but not limited to HIV and Syphilis screening in pregnant women, use of long acting reversible contraceptives, appropriate pain management approaches in patients with sickle cell disease, and behavioral therapy for ADHD and other disorders for children under age 6.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the ACLA Program Description on page 13.	
14.1.8	The MCO shall reduce overutilization of services and medications through policies such as, but not limited to, prior authorization for prescription of ADHD drugs to children younger than six years of age.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the ACLA Program Description on page 13.	
14.1.9	The MCO shall assess the quality and appropriateness of care furnished to enrollees with special health care needs.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the ACLA Program Description on page 40 (Special Health Care needs). UM Policy: 153.003 Standard and Urgent Prior (Pre-Service) Authorization pages 1 – 2 states that determinations of medical necessity are made by qualified and trained practitioners in accordance with state and federal regulations.	
14.1.10	The MCO shall promote the Louisiana Medicaid Electronic Health Records (EHR) Incentive Payment Program to further expand adoption and support contracted participating providers through provider education in the collection and reporting on CMS electronic Clinical Quality Measures.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the HEDIS Plus 2018 presentation and the Provider Incentive presentation 2018 and also in the Fax Blast – QEP Measures Update.	
14.1.11	The MCO shall collect data on race, ethnicity, primary language, disability, and geography (i.e., urban/rural). As part of the QAPI program description the MCO shall include the	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the ACLA Program Description, page 48. The plan's HEDIS dashboard, where	

Quality Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	methodology utilized for collecting the data, as well as any interventions taken to enhance the accuracy of the data collected. The MCO shall have the ability to report all performance measures stratified by race, ethnicity, primary language, disability, and geography at the request of LDH.				measures are reported by subgroups, was reviewed on-site.	
14.1.12	The QAPI Program's written policies and procedures shall address components of effective healthcare management and define processes for ongoing monitoring and evaluation that will promote quality of care. High risk and high volume areas of patient care should receive priority in selection of QAPI activities.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the ACLA Program Description on page 48.	
14.1.13	The QAPI Program shall define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the ACLA Program Description on page 10. Process improvements are discussed in the QAPI Program Evaluation.	
14.1.15	The MCO's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the MCO's governing body shall include providing strategic direction to the QAPI Program, as well as ensuring the QAPI Program is incorporated into the operations throughout the MCO.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the ACLA Program Description on page 11.	
14.1.16	The MCO shall have sufficient mechanisms in place to solicit feedback and recommendations from key stakeholders, members and their families/caregivers, and providers and use feedback and recommendations to improve performance.	Feedback reports QAPI work plan		Full	This requirement is addressed in the ACLA Program Description on page 23 (provider committees) and page 51 and 52 (member input and surveys). Member Advisory Council minutes include member representatives.	
14.1.17	The MCO shall disseminate information about findings and improvement actions taken and their effectiveness to LDH and other key stakeholders	Evidence of submission to LDH		Full	The MCO provided evidence of submission of the Program Description to LDH.	

Quality Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	as directed by LDH.					
14.1.18	The MCO shall increase the alignment of assessment and treatment with best practice standards through policies including increasing the use of evidence- based behavioral therapies as the first-line treatment for ADHD for children younger than six years of age, and other methods to increase the alignment with best practices for ADHD care for all children and particularly for children under age six.	Clinical guidelines for ADHD Provider education Provider manual		Full	The MCO submitted a series of outreach letters to members with ADHD, providing information about the condition, symptoms, and providers who can provide services. Practice guidelines are posted on the website.	
14.1.19	The MCO shall conduct peer review to evaluate the clinical competence and quality and appropriateness of care/services provided to members.	P/P provider oversight Peer review reports		Full	This requirement is addressed in the ACLA Program Description on page 41 and the Clinical Practice Guideline Performance Report.	
14.1.20	The MCO shall participate in the LDH Interdepartmental Monitoring Team (IMT) meetings and other quality improvement-related meetings/workgroups, as directed by LDH.	IMT meeting minuets		Full	This requirement is addressed in the Quality Committee Meeting Approved Minutes.	
14.1.21	The MCO shall report the percentage of members who are receiving behavioral health services whose clinical functioning is assessed over time (via clinician and/or member/family ratings on standardized tools, and/or measurable functional outcomes) to measure positive outcomes of service delivered. At a minimum, this will include children receiving CSoC services and EBPs.	BH utilization reports P/P BHUM Outcome measures and evidence that was shared with LDH		Full	This requirement is addressed in Report 333.	
14.1.21.1 14.1.21.2	.1 For members for whom outcomes are assessed, the MCO shall report on the number and percentage of members who show improved functioning with treatment, as well as the amount of improvement. .2 In addition, the MCO shall develop a strategy to increase the use of outcome measurements for all members receiving specialized behavioral health services; the strategy will be due to LDH-OBH on an annual base.	Outcome measures and results BH outcome measures and evidence shared with LDH		Full	This requirement is addressed in Report 333 and proof of submission documentation.	

Quality Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
14.2	**QAPI Committee**					
14.2.1	The MCO shall form a QAPI Committee that shall, at a minimum include:					
14.2.1.1	**QAPI Committee Members** The MCO Medical Director must serve as either the chairman or co-chairman;	QAPI Program Description Composition of QAPI Committee		Full	This requirement is addressed in the ACLA QAPI Program Description on page 16.	
14.2.1.2	The MCO Behavioral Health Director;	QAPI Program Description Composition of QAPI Committee		Full	This requirement is addressed in the ACLA QAPI Program Description on page 16.	
14.2.1.3	Appropriate MCO staff representing the various departments of the organization will have membership on the committee;	QAPI Program Description Composition of QAPI Committee		Full	This requirement is addressed in the ACLA QAPI Program Description on page 17.	
14.2.1.4	The MCO is encouraged to include a member advocate representative on the QAPI Committee; and	QAPI Program Description Composition of QAPI Committee		Full	This requirement is addressed in the ACLA QAPI Program Description on page 28. Members are represented on the Member Advisory Council.	
14.2.1.5	The MCO shall include LDH representative(s) on the QAPI Committee, as designated by LDH as non-voting member(s).	QAPI Program Description Composition of QAPI Committee		Full	This requirement is addressed in the ACLA QAPI Program Description on page 28.	
14.2.2	**QAPI Committee Responsibilities** The committee shall meet on a quarterly basis. Its responsibilities shall include:	QAPI Program Description QAPI Work Plan QAPI Committee Description including roles and responsibilities		Full	This requirement is addressed in the ACLA QAPI Program Description on, page 28. Also met by Committee Meeting minutes.	
14.2.2.1	Direct and review quality improvement (QI) activities;	QAPI Program Description		Full	This requirement is addressed in the ACLA QAPI Program Description on page 43.	
14.2.2.2	Assure than QAPI activities take place throughout the MCO;	QAPI Program Description		Full	This requirement is addressed in the Health Outcomes Workgroup Agendas, in which QI activities undertaken by the MCO are discussed.	
14.2.2.3	Review and suggest new and or improved QI activities;	QAPI Program Description		Full	This requirement is addressed in the ACLA QAPI Program Description on page 27.	
14.2.2.4	Direct task forces/committees to review areas of concern in the provision of healthcare services to	QAPI Program Description		Full	This requirement is addressed in the ACLA QAPI Program Description on page 26.	

Quality Management						
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	members;					
14.2.2.5	Designate evaluation and study design procedures;	QAPI Program Description		Full	This requirement is addressed in the ACLA QAPI Program Description on page 26.	
14.2.2.6	Conduct individual PCP and LMHP and practice quality performance measure profiling;	QAPI Program Description		Full	This requirement is addressed in the ACLA QAPI Program Description on page 13.	
14.2.2.7	Report findings to appropriate executive authority, staff, and departments within the MCO;	QAPI Program Description		Full	This requirement is addressed in the ACLA QAPI Program Description on page 14.	
14.2.2.8	Direct and analyze periodic reviews of members' service utilization patterns;	QAPI Program Description		Full	This requirement is addressed in the ACLA QAPI Program Description on page 13.	
14.2.2.9	Maintain minutes of all committee and sub-committee meetings and submit meeting minutes to LDH;	QAPI Program Description		Full	This requirement is addressed in the Committee Meeting Minutes.	
14.2.2.10	Report an evaluation of the impact and effectiveness of the QAPI program to LDH annually. This report shall include, but is not limited to, all care management services;	QAPI Program Description		Full	This requirement is addressed in the ACLA QAPI Program Description on pages 14 and 15 and submission of Report 136.	
14.2.2.11	Ensure that the QAPI committee chair attends LDH quality meetings; and	QAPI Program Description		Full	This requirement is addressed in the Committee Meeting Minutes.	
14.2.2.12	Update provider manuals and other relevant clinical content on a periodic basis as determined by the committee chairperson.	QAPI Program Description		Full	This requirement is addressed in the ACLA QAPI Program Description on page 36.	
14.2.3	**QAPI Work Plan** The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction provided by the governing body. The QAPI plan shall be submitted to LDH within thirty (30) days after the effective date of the contract and annually thereafter, and prior to implementation of revisions. The QAPI plan, at a minimum, shall:	QAPI Program Description QAPI Work Plan Evidence of timely submission of the written QAPI plan		Full	This requirement is addressed in the QAPI Work Plan Description. Proof of submission was provided.	
14.2.3.1	Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;	QAPI Program Description		Full	This requirement is addressed in the QAPI Work Plan Description.	
14.2.3.2	Include processes to evaluate the impact and effectiveness of the QAPI Program;	QAPI Program Description		Full	This requirement is addressed in the QAPI Work Plan Description on pages 14 and 15.	
14.2.3.3	Include a description of the MCO staff assigned to	QAPI Program Description		Full	This requirement is addressed in the QAPI	

Quality Management						
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	the QAPI Program, their specific training, how they are organized, and their responsibilities;				Work Plan Description on pages 18 to 22.	
14.2.3.4	Describe the role of its providers in giving input to the QAPI Program; and	QAPI Program Description		Full	This requirement is addressed in the QAPI Work Plan Description on pages 23 and 26.	
14.2.3.5	Be exclusive to Louisiana Medicaid and shall not contain documentation from other state Medicaid programs or product lines operated by the MCO.	QAPI Program Description		Full	This requirement is addressed in the QAPI Work Plan Description.	
14.2.3.6	Describe the methods for ensuring data collected and reported to LDH is valid, accurate, and reflects providers' adherence to clinical practice guidelines as appropriate.	QAPI program description		Full	This requirement is addressed in the QAPI Work Plan Description on pages 22, 42, and 63.	
14.2.3.7	Include a fidelity monitoring plan which at a minimum includes the fidelity criteria for each applicable service/provider type, sampling approach, data collection methods, tools to be used, frequency of review, and validation methods.	Monitoring plan		Full	This requirement is addressed in the QAPI Work Plan Description on pages 56 to 58.	
14.2.4 14.2.4.1	**QAPI Reporting Requirements** The MCO shall submit QAPI reports annually to LDH which, at a minimum, shall include: • Quality improvement (QI) activities; • Recommended new and/or improved QI activities; and • Results of the evaluation of the impact and effectiveness of the QAPI program.	QAPI Program Description		Full	This requirement is addressed in the QAPI Work Plan Description on pages 136 and 138.	
14.2.4.3	The MCO shall provide data reports, including but not limited to ad-hoc reports and reports for special populations (e.g., DCFS/OJJ, nursing home populations), to LDH using the specifications and format approved by LDH. The MCO shall submit the reports based on the agreed upon dates established by the MCO and LDH.	QAPI Program Description		Full	This requirement is addressed in the QAPI Work Plan Description on page 63.	
14.2.5 14.2.5.1	**Performance Measures** The MCO shall report on performance measures listed in Attachment E and in accordance with the timeline and format specified in the MCO Quality	HEDIS IDSS results PM results		Full	This requirement is addressed in the IDSS Report.	

Quality Management						
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	Companion Guide.					
14.2.5.2	The MCO shall have processes in place to monitor and self-report all performance measures.	P/P performance measures Final audit report		Full	This requirement is addressed in the Auditor's Final Audit Report and the MCO's HEDIS dashboard.	
14.2.5.3	The data shall demonstrate adherence to clinical practice guidelines and improvement in patient outcomes.	P/P performance measurement		Full	This requirement is addressed in the QAPI Work Plan Description in, Attachment A.	
14.2.5.4	The MCO shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.	P/P QAPI program description		Full	This requirement is addressed in the QAPI Work Plan Description on page 43.	
14.2.5.5	The tools and reports shall be flexible and adaptable to changes in the quality measurements required by LDH.	P/P QAPI program description		Full	This requirement is addressed in the QAPI Work Plan Description on page 14.	
14.2.5.6	The MCO shall maintain integrity, accuracy, and consistency in data reported. Upon request, the MCO shall submit to LDH detail sufficient to independently validate the data reported.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the QAPI Work Plan Description on page 42.	
14.2.5.7 14.2.5.7.1	**Incentive Based Performance Measures** Incentive Based (IB) measures are measures that may affect PMPM payments and can be identified in Attachment E annotated with "$$".	HEDIS results – incentive measures		Full	This requirement is addressed in the HEDIS IDSS.	
14.2.5.7.2	Based on an MCO's Performance Measure outcomes for CYE 12/31/2015, a maximum of $22,25000,000 ($250,000 per measure) in October following the measurement CY will be withheld from payment if specified performance measures fall below LDH's established benchmarks for improvement.					
14.2.5.7.3	LDH expressly reserves the right to modify existing performance IB measures. Any changes in the Incentive Based performance measures will require an amendment to the Contract and LDH will provide six (6) months' notice of such change.	P/P Performance measures		Full	This requirement is addressed in the QAPI Work Plan Description on page 59.	
14.2.5.8 14.2.5.8.1	**Performance Measures Reporting** The MCO shall utilize systems, operations, and performance monitoring tools and/or automated	HEDIS results IDSS submission Final audit report				

Quality Management						
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	methods for monitoring.					
14.2.5.8.2	The tools and reports will be flexible and adaptable to changes in the quality measurements required by LDH.			Full	This requirement is addressed in the QAPI Work Plan Description on page 14.	
14.2.5.8.3	The MCO shall have processes in place to monitor and self-report performance measures as specified in Section 14.2.5 Performance Measures.	P/P performance measures		Full	This requirement is addressed in the IDSS and the MCO's HEDIS dashboard.	
14.2.5.9	Beginning in 2018, the MCO shall submit audited HEDIS results to NCQA according to NCQA's HEDIS data submission timeline for health plans to submit final Medicaid HEDIS results (typically June 15 of each calendar year).	P/P performance measures		Full	This requirement is addressed in the Auditor's Final Audit Report, the IDSS, and the MCO's HEDIS dashboard.	
14.2.8 14.2.8.1	**Performance Improvement Projects** The MCO shall establish and implement an ongoing program of Performance Improvement Projects (PIP) that focuses on clinical and non-clinical performance measures as specified in 42 CFR §438.330.	PIP proposal/reports P/P performance input projects PIP meeting minutes		Full	This requirement is addressed in the MCO's Prematurity and ADHD PIP Reports and the IET proposal.	
14.2.8.2	The MCO shall perform two (2) LDH-approved PIPs listed in Appendix DD – Performance Improvement Projects for the initial three-year term of the contract. LDH may require up to two (2) additional projects for a maximum of four (4) projects.	PIP proposal/reports P/P performance input projects PIP meeting minutes		Full	This requirement is addressed in the MCO's Prematurity and ADHD PIP Reports.	
14.2.8.2.1	Effective 2/1/16, the MCO shall perform a minimum of one (1) additional LDH-approved behavioral-health PIP each contract year.	PIP proposal/reports P/P performance input projects PIP meeting minutes		Full	This requirement is addressed in the MCO's ADHD PIP Report and IET proposal.	
14.2.8.3	Performance Improvement Projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement sustained over time, with favorable effects on health outcomes and enrollee satisfaction. Each project must involve the following: • Measurement of performance using objective	PIP proposal/reports P/P performance input projects PIP meeting minutes		Full	This requirement is addressed in the MCO's Prematurity and ADHD PIP Reports.	

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	quality indicators; • Implementation of interventions to achieve improvement in the access to and quality of care; • Evaluation of the effectiveness of the interventions; and • Planning and initiation of activities for increasing or sustaining improvement.					
14.2.8.4	Within three (3) months of the execution of the Contract and at the beginning of each Contract year thereafter, the MCO shall submit, in writing, a general and a detailed description of each Performance Improvement Project to LDH for approval. The detailed description shall include: • An overview explaining how and why the project was selected, the status of the PIP, and its relevance to the MCO members and providers; • The study question; • The study population; • The quantifiable measures to be used, including the baseline and goal for improvement; • Baseline methodology; • Data sources; • Data collection methodology and plan; • Data collection plan and cycle, which must be at least monthly; • Results with quantifiable measures; • Analysis with time period and the measures covered; • Explanation of the methods to identify opportunities for improvement; and • An explanation of the initial interventions to be taken.	PIP proposal/reports P/P performance input projects PIP meeting minutes		Full	This requirement is addressed in the MCO's Prematurity and ADHD PIP Reports and the IET proposal.	
14.2.8.5	PIPs used to measure performance improvement shall include diagrams (e.g. algorithms and/or flow	PIP proposal/reports P/P performance input		Full	This requirement is addressed in the MCO's Prematurity and ADHD PIP Reports.	

Quality Management						
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	charts) for monitoring and shall: • Target specific conditions and specific health service delivery issues for focused system-wide and individual practitioner monitoring and evaluation; • Use clinical care standards and/or practice guidelines to objectively evaluate the care the MCO delivers or fails to deliver for the targeted clinical conditions; • Use appropriate quality indicators derived from the clinical care standards and/or practice guidelines to screen and monitor care and services delivered; • Implement system interventions to achieve improvement in quality, including a (PDSA) cycle; • Evaluate the effectiveness of the interventions; • Provide sufficient information to plan and initiate activities for increasing or sustaining improvement; • Monitor the quality and appropriateness of care furnished to enrollees with special health care needs; • Reflect the populations served in terms of age groups, disease categories, and special risk status, • Ensure that multi-disciplinary teams will address system issues; • Include objectives and quantifiable measures based on current scientific knowledge and clinical experience and have an established goal benchmark; • Validate the design to assure that the data to be abstracted during the QI project is accurate, reliable and developed according to generally accepted principles of scientific	projects PIP meeting minutes				

Quality Management						
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	research and statistical analysis, and • Maintain a system for tracking issues over time to ensure that actions for improvement are effective.					
14.2.10 14.2.10.1	**Member Satisfaction Surveys** The MCO shall conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to members.	CAHPS report		Full	This requirement is addressed in the Morpace CAHPs Report.	
14.2.10.2 14.2.10.3	The MCO shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The MCO's vendor shall perform CAHPS Adult surveys; and CAHPS Child surveys, including the Children with Chronic Conditions survey supplement.	CAHPS Vendor contract		Full	This requirement is addressed in the MCO's contracting with Morpace, an NCQA-certified CAHPs survey vendor.	
14.2.10.4	Survey results and a description of the survey process shall be reported to LDH separately for each required CAHPS survey. CAHPS survey results are due with all other performance measures.	CAHPS report		Full	This requirement is addressed in the Morpace Adult Medicaid Summary Report and the Child Medicaid w/ CCC Survey Summary Report.	
14.2.10.5	The CAHPS survey results shall be reported to LDH or its designee for each survey question. These results may be used by LDH for public reporting. Responses will be aggregated by LDH or its designee for reporting. The survey shall be administered to a statistically valid random sample of clients who are enrolled in the MCO at the time of the survey.	CAHPS data file		Full	Proof of submission was provided to address this requirement.	
14.2.10.6	The surveys shall provide valid and reliable data for results.	Evidence CAHPS vendor was used		Full	This requirement is addressed in the MCO's use of an NCQA-certified vendor, Morpace, to conduct the CAHPs surveys.	
14.2.10.7	Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.	CAHPS reports		Full	This requirement is addressed in the Morpace Adult Medicaid Summary Report and the Child Medicaid w/ CCC Survey Summary Report.	
14.2.10.8	The most current CAHPS Health Plan Survey	CAHPS reports		Full	This requirement is addressed in the Adult	

Quality Management						
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14.2.10.8.1 14.2.10.8.2 14.2.10.8.3 14.2.10.8.4 14.2.10.8.5	(currently 5.0) for Medicaid Enrollees shall be used and include: .1 Getting Needed Care, .2 Getting Care Quickly, .3 How Well Doctors Communicate, .4 Health Plan Customer Service, .5 Global Ratings.				Medicaid Summary Report and the Child Medicaid w/ CCC Survey Summary Report.	
14.2.10.9	The MCO's vendor shall perform a LDH-approved behavioral health survey to be standardized across the MCOs. The survey results shall be reported to LDH on an annual basis.	P/P Behavioral health survey Timeline for BH survey administration BH survey results, if administered		Full	This requirement is addressed in the Morpace Behavioral Health Satisfaction Report.	
14.4	**Health Plan Accreditation**					
14.4.1	The MCO must attain health plan accreditation by NCQA. If the MCO is not currently accredited by NCQA, the MCO must attain accreditation by meeting NCQA accreditation standards.	Accreditation Status including copy of accreditation report if accredited		Full	This requirement is addressed in the NCQA Accreditation Certificate.	
14.4.2	The MCO's application for accreditation must be submitted at the earliest point allowed by the organization. The MCO must provide LDH with a copy of all correspondence with NCQA regarding the application process and the accreditation requirements.	Accreditation Status including copy of accreditation report if accredited		Full	Proof of submission was provided to meet this requirement.	
14.4.3	The MCO shall provide LDH with a copy of its most recent accreditation review including:	Accreditation Status including copy of accreditation report if accredited		Full	Proof of submission was provided to meet this requirement.	
14.4.3.1	Accreditation status, survey type, and level (as applicable);	Accreditation Status including copy of accreditation report if accredited		Full	This requirement is addressed in the NCQA Accreditation Certificate and letter.	
14.4.3.2	Accreditation results, including recommended actions or improvements, corrective action plan,	Accreditation Status including copy of		Full	This requirement is addressed in the NCQA Accreditation Report (scores 1 and 2).	

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	and summaries of findings; and	accreditation report if accredited				
14.4.3.3	Expiration date of the accreditation.	Accreditation Status including copy of accreditation report if accredited		Full	This requirement is addressed in the NCQA Accreditation Certificate.	
14.4.4	Achievement of provisional accreditation status shall require a CAP within thirty (30) calendar days of receipt of the Final Report from NCQA. Failure to obtain full NCQA accreditation and to maintain the accreditation thereafter shall be considered a breach of the Contract and shall result in termination of the Contract.	Accreditation Status including copy of accreditation report if accredited		Full	This requirement is addressed in the NCQA Accreditation Certificate and letter.	
14.5	**Member Advisory Council**					
14.5.1	The MCO shall establish a Member Advisory Council to promote collaborative effort to enhance the service delivery system in local communities while maintaining member focus and allow participation in providing input on policy and programs.	Member Advisory Council Plan Member Advisory Council Composition Member Advisory Council Description including roles and responsibilities		Full	This requirement is addressed in the PS141 Member Advisory Committee Policy. Evidence the committee met quarterly is addressed in the minutes posted online.	
14.5.2	The Council is to be chaired by the MCO's Administrator/CEO/COO or designee and will meet at least quarterly.	Member Advisory Council Plan Composition of Member Advisory Council		Full	This requirement is addressed in the QAPI Program Description: Member Advisory Council on page 35. Evidence the committee met quarterly is addressed in the minutes posted online.	
14.5.3	Every effort shall be made to include a broad representation of both members/families/significant others, member advocacy groups and providers that reflect the population and community served. At least one family member/caregiver of a child with special health care needs shall have representation on the committee. Members/families/significant others and member advocacy groups shall make up at least fifty per cent (50%) of the membership.	Member Advisory Council Plan Member Advisory Council Composition		Full	This requirement is addressed in the QAPI Program Description: Member Advisory Council on page 35 and Report PS141: ACLA Member Advisory Council Annual Report on page 2. Minutes are posted online.	

Quality Management						
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14.5.4.	The MCO shall provide an orientation and ongoing training for Council members so they have sufficient information and understanding to fulfill their responsibilities.	Member Advisory Council Plan		Full	This requirement is addressed in the MAC meeting minutes and the MAC Charter. The MAC meetings have orientation at the beginning of the meeting. The Charter provides an overview of the purpose of the MAC, its goals, and frequency of the meetings.	
14.5.5.	The MCO shall develop and implement a Member Advisory Council Plan that outlines the schedule of meetings and the draft goals for the council that includes, but is not limited to, member's perspectives to improve quality of care. This plan shall be submitted to LDH within thirty (30) days of signing the Contract and annually thereafter.	Member Advisory Council Plan Evidence of timely submission of a Member Advisory Council Plan		Full	This requirement is addressed in Report PS141: ACLA Member Advisory Council Annual Report.	
14.5.6.	LDH shall be included in all correspondence to the Council, including agenda and Council minutes. Additionally, all agenda and Council minutes shall be posted to the MCO website in English and Spanish, with any member-identifying information redacted.	Member Advisory Council Plan		Full	This requirement is addressed on the website: http://amerihealthcaritasla.com/community/mac/mac.aspx	
14.6 14.6.1	**Fidelity to Evidence-Based Practices** The MCO will establish a fidelity-monitoring plan in place for Evidenced Based Practice providers to ensure providers' adherence to evidence-based and evidence-informed practices to ensure the core elements of the intervention are maintained and minimum fidelity standards are met. The providers maintain fidelity monitoring for Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Homebuilders and Assertive Community Treatment Act (ACT) as part of the certification/credentialing process. The MCO will maintain Memorandums of Understanding (MOUs) with the fidelity monitoring agencies for Family Functional Therapy, Multisystemic Therapy, and Homebuilders. The MOUs outline a	Fidelity monitoring plan MOUs Evidence of submission to LDH		Full	This requirement is addressed in the QAPI Program Description on page 56.	

Quality Management						
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	collaborative protocol between the MCO and the monitoring agencies to ensure the appropriate exchange of fidelity reports and other quality reports.					
14.6.2	The MCO will manage the fidelity monitoring process for Assertive Community Treatment (ACT) providers to ensure minimum fidelity standards utilizing the LDH specified ACT Monitoring tool. The MCO shall ensure their staff are properly trained on utilization of the identified ACT Monitoring tool.	Fidelity monitoring plan Evidence of submission to LDH		Full	This requirement is addressed in the QAPI Program Description on page 58.	
14.6.3	A formal fidelity-monitoring plan will be submitted to the State within 30 days of the beginning of the contract, which includes at a minimum the fidelity criteria for each applicable service/provider type, sampling approach, data collection methods, tools to be used, frequency of review, and validation methods. The monitoring system shall include a formalized monitoring review process of all providers' performance on an ongoing basis including a procedure for formal review with site-visits. Site visits shall be conducted according to a periodic schedule individualized by provider type determined by the MCO and approved by LDH. Reports will be submitted to LDH according to the frequency established in the fidelity monitoring plan submitted to the State, but no less than once per year.	Fidelity monitoring plan Site visit reports Evidence of submission to LDH		Full	This requirement is addressed in the QAPI Program Description on page 56, where the Fidelity Monitoring Plan is described. Site visits are reference in the Fidelity Monitoring Plan – Semi-Annual Report.	
14.8 14.8.1	**Adverse Incident Reporting** The MCO shall develop, submit, and implement a critical reporting and management procedures for the behavioral health population, subject to review and approval by LDH. The procedure shall describe how the MCO will detect, report, remediate (when applicable), and work to prevent the future re-occurrence of incidents.	P/P BH reporting Critical incident reporting system		Full	This requirement is addressed in the QAPI Program Description on page 56.	

Quality Management						
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14.8.2	The MCO, as directed by LDH, may be required to utilize a third party incident management system in lieu of, or in addition to, its own incident management reporting system. Connection to this third party system is at the cost of the MCO. It shall be the MCO's decision to replace its own incident management system with the requested third party system or to utilize both systems for incident management.					
14.8.3	The MCO shall submit reports to LDH concerning quality of care concerns and adverse incidents, as documented in the Behavioral Health Companion Guide.	P/P BH reporting		Full	This requirement is addressed in the 326 ACLA Adverse Incidents Report.	
14.9	**Provider Monitoring Plan and Reporting**					
14.9.1	The MCO shall develop and implement a plan for monitoring specialized behavioral health providers and facilities across all levels of care, which incorporates onsite reviews and member interviews. The MCO shall submit the plan to LDH for approval within 30 calendar days of contract execution and at least 60 days prior to revision. The MCO's plan shall comply with all the requirements as specified by LDH:	P/P BH reporting Evidence of report submission to LDH		Full	This requirement is addressed in the 356 Provider Monitoring Strategy. Proof of submission was provided to address this requirement.	
14.9.1.1	Review criteria for each applicable provider type/level of care;			Full	This requirement is addressed in the 356 Provider Monitoring Strategy o, page 1.	
14.9.1.2	Sampling approach including number and percent of onsite audits by provider type, number and percent of desktop audits, and number of charts to be reviewed at each provider location;			Full	This requirement is addressed in the 356 Provider Monitoring Strategy on page 1.	
14.9.1.3	Member interview criteria;			Full	This requirement is addressed in the 356 Provider Monitoring Strategy on page 1.	
14.9.1.4	Random audit selection criteria;			Full	This requirement is addressed in the 356 Provider Monitoring Strategy on Sampling.	
14.9.1.5	Tools to be used;			Full	This requirement is addressed in the 356 Provider Monitoring Strategy on page 1.	

Quality Management						
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14.9.1.6	Frequency of review, including schedule of reviews by provider type;			Full	This requirement is addressed in the 356 Provider Monitoring Strategy on page 5.	
14.9.1.7	Corrective actions to be imposed based on the degree of provider non-compliance with review criteria elements on both an individual and systemic basis;			Full	This requirement is addressed in the 356 Provider Monitoring Strategy and the Provider Corrective Action letter.	
14.9.1.8	Plan for ensuring corrective actions are implemented appropriately and timely by providers; and			Full	This requirement is addressed in the 356 Provider Monitoring Strategy and the Provider Corrective Action letter.	
14.9.1.9	Inter-rater reliability testing methods.			Full	This requirement is addressed in the 356 Provider Monitoring Strategy(#15) on page 7.	
14.9.2	At a minimum, the MCO's sampling approach shall result in a statistically significant representative sample with a confidence interval of 95% + or - 5 for each level of care. The sample shall be random and include providers who have served at least one member during the review period. Levels of care include mental health outpatient, substance use outpatient, and inpatient / residential. Additional levels of care may be added at the discretion of LDH.	P/P BH reporting		Full	This requirement is addressed in the 356 Provider Monitoring Strategy on Sampling.	
14.9.3	The MCO's review criteria shall address the following areas at a minimum:					
14.9.3.1	Adherence to clinical practice guidelines;			Full	This requirement is addressed in the 356 Provider Monitoring Strategy and the tool elements.	
14.9.3.2	Member rights and confidentiality, including advance directives and informed consent;			Substantial	Confidentiality is noted as a review element in the 356 Provider Monitoring Strategy on page 1 but is not an element in the review tool. <u>Recommendation:</u> ACLA should explicitly add maintenance of "member confidentiality" in the provider monitoring review tool, perhaps in the Member Rights section of the tool that	ACLA has incorporated the maintenance of "member confidentiality to the review tool. See the document attached below. The template is being used effective 8/12/2019.

Quality Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					covers release of information, page 8.	
14.9.3.3	Cultural competency;			Full	This requirement is addressed in the 356 Provider Monitoring Strategy and tool elements.	
14.9.3.4	Patient safety;			Full	This requirement is addressed in the 356 Provider Monitoring Strategy and tool elements.	
14.9.3.5	Compliance with adverse incident reporting requirements;			Full	This requirement is addressed in the 356 Provider Monitoring Strategy and tool elements.	
14.9.3.6	Appropriate use of restraints and seclusion, if applicable;			Full	This requirement is addressed in the 356 Provider Monitoring Strategy and tool elements.	
14.9.3.7	Treatment Planning components, including criteria to determine: the sufficiency of assessments in the development of functional treatment recommendations; the treatment plan is individualized and appropriate for the enrollee and includes goals, Specific, Measurable, Action-Oriented, Realistic, and Time-Limited (SMART) objectives, and the appropriate service to achieve goal/objective; individualized crisis plan; members'/families' cultural preferences are assessed and included in the development of treatment plans; the treatment plan has been reviewed regularly and updated as the needs of the member changes; the treatment plan includes the involvement of family and other support systems in establishing treatment goals/objectives; the treatment plan includes evidence of implementation as reflected in progress notes; and evidence that the member is either making progress toward meeting goals/objectives or there is evidence the treatment has been revised/updated to meet			Full	This requirement is addressed in the 356 Provider Monitoring Strategy and tool elements.	

Quality Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	the changing needs of the member; and					
14.9.3.8	Continuity and coordination of care, including adequate discharge planning			Full	This requirement is addressed in the 356 Provider Monitoring Strategy and tool elements.	
14.9.4	The MCO shall take steps to require adoption of clinical practice guidelines by specialized behavioral health providers and measure compliance with the guidelines until such point that 90% or more of providers consistently achieve at least 80% compliance based on MCO measurement findings.					
14.9.5	The MCO shall ensure that an appropriate corrective action is taken when a provider furnishes inappropriate or substandard services as determined by the MCO, when a provider does not furnish a service that should have been furnished, or when a provider is out of compliance with federal and state regulations. The MCO shall monitor and evaluate corrective actions taken to ensure that appropriate changes have been made in a timely manner.	Provider Monitoring P/P		Full	This requirement is addressed in the 356 Provider Monitoring Strategy on pages 6 and 7.	
14.9.6	The MCO shall submit quarterly reports which summarize monitoring activities, findings, corrective actions, and improvements for Specialized Behavioral Health Services.	Provider Monitoring P/P Provider Monitoring Reports		Full	This requirement is addressed in the 358 Provider Monitoring Summary.	
14.10	**Outcome Assessment for Specialized Behavioral Health Services**					
14.10.1	The MCO shall assess the treatment progress and effectiveness of Specialized Behavioral Health Services for both children and adults using standardized clinical outcome tools and measures, according to the guidelines specified by LDH.	BH outcome assessment plan Assessment Reports		Full	This requirement is addressed in Report 333: Strategy for Increasing Outcome Measurement for Members Receiving Specialized Behavioral Health Services.	
14.10.2	The MCO shall ensure providers and appropriate MCO staff are adequately trained/ certified in the use of such tools and such training/certification is current.	BH outcome assessment plan Training materials Evidence of Training Attendance		Full	This requirement is addressed in Report 333: Strategy for Increasing Outcome Measurement for Members Receiving Specialized Behavioral Health Services.	

Quality Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
14.10.3	The MCO shall be responsible for data collection of outcome data, data validation activities, and reporting to the LDH.	BH outcome assessment plan		Full	This requirement is addressed in Report 355: EBP Report.	

Fraud, Abuse, and Waste Prevention

Fraud, Abuse, and Waste Prevention						
Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Plan Documentation(MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
15.1	**General Requirements**					
15.1.1	The MCO and its subcontractors shall comply with all state and federal laws and regulations relating to fraud, abuse and waste in the Medicaid and CHIP programs, including but not limited to 42 CFR 438.1-438.812 and La.R.S. 46:437.1-437.14; LAC 50:1.4101-4235 and Sections 1128, 1156, and 1902(a)(68) of the Social Security Act..					
15.1.2	The MCO's Program Integrity Officer and CEO or COO shall meet with LDH and the state's Office of Attorney General Medicaid Fraud Control Unit (MFCU) quarterly, annually, and at LDH's request, to discuss fraud, abuse, waste, neglect and overpayment issues. For purposes of this Section, the MCO's Program Integrity Officer shall serve as the primary point of contact for the MCO on issues related to Fraud, Abuse, and Waste Prevention.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 3.	
15.1.3	The MCO and its subcontractors shall cooperate and assist the state and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, abuse or waste. At any time during normal business hours, CMS, the Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, LDH, and/or any of the designees of the above, and as often as they may deem necessary during the Contract period and for a period of ten (10) years from the expiration date of the Contract (including any extensions to the Contract), or from the date of completion of any audit, whichever is later, shall have the right to inspect or otherwise evaluate the quality, appropriateness, and	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on pages 12 to 13.	

Fraud, Abuse, and Waste Prevention						
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	timeliness of services provided under the terms of the Contract and any other applicable rules. MFCU shall be allowed access to the place of business and to all Medicaid records of any contractor, subcontractor, or provider during normal business hours, except under special circumstances determined by the MFCU when after-hour admission will be allowed.					
15.1.4	The MCO and its subcontractors shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, LDH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with MCO clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on pages 12 to 13.	
15.1.5	The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained.					
15.1.6	The MCO and its providers and subcontractors shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on pages 12 to 13.	
15.1.7	MCO's employees consultants, and its subcontractors and their employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 12.	

Fraud, Abuse, and Waste Prevention						
Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	proceedings, pre-trial conferences, hearings, trials, and in any other process.					
15.1.8	The MCO and its subcontractors shall provide access to LDH and/or its designee to all information related to grievances and appeals files by its members. LDH shall monitor enrollment and termination practices and ensure proper implementation of the MCO's grievance procedures, in compliance with 42 CFR §438.226-228.	FWA Compliance Plan		Full	This requirement is addressed in Policy and Procedure Member Grievances on page 10.	
15.1.9	The MCO shall certify all statements, reports and claims, financial and otherwise, as true, accurate, and complete. The MCO shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, the Contract, and LDH policy.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 10.	
15.1.10	The MCO will report to LDH, within three (3) business days, when it is discovered that any MCO employee(s), network provider, subcontractor, or subcontractor's employee(s) have been excluded, suspended, or debarred from any state or federal healthcare benefit program via the designated LDH Program Integrity contact.	FWA Compliance Plan Network Provider Enrollment & Disclosure Forms		Full	This requirement is addressed in the Compliance Program Description on page 13 and discussion during on-site visit.	
15.1.11	The MCO and its subcontractors shall have surveillance and utilization control programs and procedures pursuant to (42 CFR §438.608(a)(1)) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The MCO shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud, waste, and abuse activities.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 11 and the 2019 ACLA Program Integrity Plan.	
15.1.12	The MCO, as well as its subcontractors and providers, whether contract or non-contract, shall	FWA Compliance Plan Network Provider		Full	This requirement is addressed in the Compliance Program Description on page 11.	

Fraud, Abuse, and Waste Prevention						
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	comply with all federal requirements (42 CFR §455.104 and 42 CFR §438.610) on disclosure reporting. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request.	Enrollment & Disclosure Forms				
15.1.13	The MCO, as well as its subcontractors and providers, shall comply with all federal requirements (42 C.F.R. §1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall screen their owners and employees against the federal exclusion databases (such as LEIE and System for Award Management). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or the MCO dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.	FWA Compliance Plan Network Provider Enrollment & Disclosure Forms Employee Disclosure Forms		Full	This requirement is addressed in the Compliance Program Description on page 11.	
15.1.14	The MCO shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the MCO in preventing and detecting potential fraud, waste, and abuse. At a minimum the MCO shall have one (1) full-time investigator physically located within Louisiana for every 50,000 members or fraction thereof. This full-time position(s) is/are in addition to the Program	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 4, the Program Integrity Organization Chart-Louisiana, and Member by Plan ID.	

Fraud, Abuse, and Waste Prevention						
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	Integrity Officer and must be located in-state. LDH may approve written requests with detailed justification to substitute another SIU position in place of an investigator position.					
15.1.15	LDH or its designee will notify the MCO when it is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria:	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 17.	
15.1.15.1	The improperly paid funds have already been recovered by the State of Louisiana, either by Louisiana Medicaid directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to false claims act cases; or	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 16.	
15.1.15.2	The improperly paid funds have already been recovered by the States Recovery Audit Contractor (RAC) contractor; or	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 16.	
15.1.15.3	When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Louisiana, are the subject of pending Federal or State litigation or investigation, or are being audited by the Louisiana RAC.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 17.	
15.1.16	The prohibition described above in Section 15.1.15 shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. In the event that the MCO obtains funds in cases where recovery recoupment or withhold is prohibited under this Section, the MCO will return the funds to LDH.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 17.	
15.1.17	The MCO shall confer with LDH before initiating any recoupment or withhold of any program integrity-related funds as defined in 15.1.15 (see	FWA Compliance Plan Payment Suspension P/P		Full	This requirement is addressed in the Compliance Program Description on page 15 and email communication with LDH shared	

Fraud, Abuse, and Waste Prevention						
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	15. 7 for audit coordination procedure) to ensure that the recovery, recoupment, or withhold is permissible..				during on-site visit.	
15.1.18	**Reporting and Investigating Suspected Fraud and Abuse**					
15.1.18.1	The MCO and its subcontractors shall cooperate with all appropriate state and federal agencies, including MFCU, in investigating fraud and abuse.					
15.1.18.2	The MCO shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §455.13, §455.14, §455.21) both internally and for its subcontractors.	FWA Compliance Plan		Full	This requirement is addressed in the Fraud and Abuse Detection Policy and Procedure and the Receipt of Referrals Policy and Procedure.	
15.1.18.3	The MCO shall notify MFCU and LDH simultaneously and in a timely manner regarding all internal (such as identified patterns of data mining outliers, audit concerns, critical incidences) and external (such as hotline calls) tips with potential implications to Louisiana Medicaid providers' billing anomalies and/or to safety of Medicaid enrollees that results in a full investigation (42 CFR §455.15). Along with a notification, the MCO shall take steps to triage and/or substantiate these tips and provide simultaneous and timely updates to MFCU and LDH when the concerns and/or allegations of any tips are authenticated.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 13 and in on-site discussion with the MCO.	
15.1.18.4	The MCO shall report all tips, confirmed or suspected fraud, waste and abuse to LDH and the appropriate agency as follows:	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 13.	
15.1.18.4.1	All tips (regarding any potential billing or claims issue identified through either complaints or internal review received within the previous month) shall be reported to LDH Program Integrity monthly; LDH	FWA Compliance Plan Evidence of report submission		Full	This requirement is addressed in the Compliance Program Description on page 14 and by evidence of monthly communication with LDH provided on-site by MCO.	
15.1.18.4.2	Suspected fraud and abuse in the administration of the program shall be reported to LDH Program	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 14.	

Fraud, Abuse, and Waste Prevention						
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	Integrity and MFCU;					
15.1.18.4.3	All confirmed or suspected provider fraud and abuse shall immediately be reported to LDH Program Integrity and MFCU; and	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 14.	
15.1.18.4.4	All confirmed or suspected enrollee fraud and abuse shall be reported immediately, in writing, to LDH Program Integrity and local law enforcement of the enrollee's parish of residence..	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 14.	
15.1.18.5	When making a referral of suspected fraud, the MCO shall utilize a Fraud Reporting Form deemed satisfactory by LDH under the terms of this Contract. The MCO shall report suspected provider fraud using the LDH Provider Fraud Referral Form	FWA Compliance Plan Provider referral forms		Full	This requirement is addressed in the Compliance Program Description on page 13.	
15.1.18.6	The MCO shall be subject to a civil penalty, to be imposed by the LDH, for willful failure to report fraud and abuse by employees, subcontractors, beneficiaries, recipients, enrollees, applicants, or providers to LDH MFCU, as appropriate.					
15.1.18.7	The MCO shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the MCO shall not take any of the following actions as they specifically relate to Medicaid claims:	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 15.	
15.1.18.7.1	Contact the subject of the investigation about any matters related to the investigation;	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 16.	
15.1.18.7.2	Enter into or attempt to negotiate any settlement or agreement regarding the incident; or	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 16.	
15.1.18.7.3	Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 16.	

Fraud, Abuse, and Waste Prevention						
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15.1.18.8	The MCO shall promptly provide the results of its preliminary investigation to LDH or the agency to whom the incident was reported, or to another agency designated by the agency that received the report.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 15.	
15.1.18.9	The MCO and its subcontractors shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview MCO employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 12.	
15.1.18.10	The MCO and/or its subcontractors are to suspend payment to a network provider when the state determines there is a credible allegation of fraud, unless the state determines there is good cause for not suspending payments to the network provider pending the investigation. The MCO is responsible for sending the network provider the required notice and appeal rights as required by the code of federal regulation.			Full	This requirement is addressed in the State-Initiated Provider Payment Suspension Policy and Procedure on page 2.	
15.1.19	The State shall not transfer its law enforcement functions to the MCO.					
15.1.20	The MCO and/or subcontractors shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider comply with this Section, Section 15 of this Contract.	FWA Compliance Plan Provider Agreement Form		Full	This requirement is addressed in Ancillary, Hospital, Specialist, and PCP Agreement on page 12.	
15.1.21	The MCO shall notify LDH when the MCO or its subcontractor denies a provider credentialing application or disenrolls a provider for program integrity-related reasons or otherwise limits the	FWA Compliance Plan Provider Enrollment, Disclosure & Credentialing Forms		Full	This requirement is addressed in Policy CP210.103 on page 7 and the 145 Report.	

Fraud, Abuse, and Waste Prevention						
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	ability of providers to participate in the program for program integrity reasons.					
15.1.22	The MCO shall report overpayments made by LDH to the MCO within 60 calendar days from the date the overpayment was identified.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 13.	
15.1.23	Unless prior written approval is obtained from LDH, the MCO shall not employ extrapolation methods to derive an overpayment in a provider audit.	FWA Compliance Plan		Full	This requirement is addressed in Policy 106.100.022 on page 7.	
15.2						
15.2.1	In accordance with 42 CFR §438.608(a), the MCO and its subcontractors, to the extent that the subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under the contract between the MCO and the state, shall have a compliance program that includes administrative and management arrangements or procedures, including a mandatory Fraud and Abuse Compliance Plan designed to prevent, reduce, detect, correct, and report known or suspected fraud, abuse, and waste in the administration and delivery of services.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 18.	
15.2.2	In accordance with 42 CFR §438.608 (a)(1)(ii), the MCO's compliance program shall designate a contract compliance officer who is responsible for developing and implementing written policies, procedures, and standards to ensure compliance with the requirements of this contract and all applicable Federal and State requirements, and who reports directly to the CEO and board of directors. .	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 3.	
15.2.3	The MCO shall have an adequately staffed Medicaid Program Integrity office with oversight by the Program Integrity Officer	FWA Compliance Plan PI Org chart and resumes		Full	This requirement is addressed in the Compliance Program Description on page 5 and in on-site discussions with the MCO.	
15.2.4	The MCO shall establish and implement	FWA Compliance Plan		Full	This requirement is addressed in the	

Fraud, Abuse, and Waste Prevention						
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	procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, promptly respond to compliance issues as they are raised, investigate potential compliance problems as identified in the course of self-evaluation and audits, correct such problems promptly and thoroughly, including coordinating with law enforcement agencies if issues are suspected to be criminal in nature, to reduce the potential for recurrence, and conduct ongoing compliance with the requirements under the contract.				Compliance Program Description on page 9.	
15.2.6	In accordance with 42 CFR 438.608(a)(1)(iii), the compliance program shall establish a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with oversight of the compliance program and its compliance with the requirements under this contract.	FWA Compliance Plan Compliance Committee Charter Compliance Committee meeting minutes		Full	This requirement is addressed in the Compliance Program Description on page 4 and Compliance Committee Meeting Minutes.	
15.2.6	The MCO shall submit the Fraud and Abuse Compliance Plan within thirty (30) days from the date the Contract is signed. The MCO shall submit updates or modifications to LDH for approval at least thirty (30) days in advance of making them effective. LDH, at its sole discretion, may require that the MCO modify its compliance plan. The MCO compliance program shall incorporate the policy and procedures as follows:	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 3.	
15.2.6.1	Written policies, procedures, and standards of conduct that articulate MCO's commitment to comply with all applicable federal and state standards;			Full	This requirement is addressed in the Compliance Program Description on page 6.	
15.2.6.2	Effective lines of communication between the Contract Compliance Officer and the MCO's employees, providers and contractors			Full	This requirement is addressed in the Compliance Tools for Effective Lines of Communication on page 2, and in online reporting tools.	

Fraud, Abuse, and Waste Prevention						
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15.2.6.3	Enforcement through well-publicized disciplinary guidelines;			Full	This requirement is addressed in the Code of Conduct and Ethics and Disciplinary Action, and in on-site discussion with MCO.	
15.2.6.4	Procedures for ongoing monitoring and auditing of MCO systems, including, but not limited to, claims processing, billing and financial operations, enrollment functions, member services, continuous quality improvement activities, and provider activities;			Full	This requirement is addressed in the Compliance Program Description on page 9.	
15.2.6.5	Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the Contract Compliance Officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel;			Full	This requirement is addressed in the Compliance Program Description on page 9.	
15.2.6.6	Provisions for internal monitoring and auditing reported fraud, abuse, and waste in accordance with 42 CFR §438.608(b)(4-6);			Full	This requirement is addressed in the Program Integrity Fraud and Abuse Detection Policy and Procedure.	
15.2.6.7	Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly.			Full	This requirement is addressed in the Program Integrity Policy Investigative Site Visits Policy and Procedure.	
15.2.3.8	Protections to ensure that no individual who reports compliance plan violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the MCO. The MCO shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible. Anyone who believes that he or she has been retaliated against may report this violation to LDH and/or the U.S. Office of Inspector General.			Full	This requirement is addressed in the Program Integrity Policy Investigative Site Visits Policy and Procedure.	
15.2.6.9	Procedures for prompt notification to LDH			Full	This requirement is addressed in the State	

Fraud, Abuse, and Waste Prevention						
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	when the MCO receives information about changes in a member's circumstance that may affect the member's eligibility including changes in the member's residence and death of a member.				Notifications for Member Data Changes Policy.	
15.2.6.10	Procedures for prompt notification to LDH when the MCO receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the program.			Full	This requirement is addressed in the Network Composition and Changes Policy and Procedure.	
15.2.6.11	Provisions for a prompt response to detected offenses and for development of corrective action initiatives related to the Contract in accordance with 42 CFR §438.608(b)(7);			Full	This requirement is addressed in the Compliance Program Description on page 10.	
15.2.6.12	Effective training and education system for the Contract Compliance Officer, program integrity investigators, managers, and members to ensure that they know and understand the federal and state standards and requirements of MCO's contract;			Full	This requirement is addressed in the Compliance Program Description on page 7 and in New Hire Orientation documents.	
15.2.6.13	Fraud, Waste and Abuse Training shall include, but not be limited to: • Annual training of all employees; • New hire training within thirty (30) days of beginning date of employment.			Full	This requirement is addressed in the Compliance Program Description on page 7 and documentation of ACLA training participation.	
15.2.6.14	The MCO will require new employees to complete and attest to training modules within thirty (30) days of hire related to the following in accordance with federal and state laws: • MCO Code of Conduct Training • Privacy and Security – Health Insurance Portability and Accountability Act • Fraud, waste, and abuse identification and reporting procedures • Federal False Claims Act and employee whistleblower protections			Full	This requirement is addressed in the ACLA Compliance Program Description on page 7, and New Hire Orientation ACLA.pptx.	

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	• Procedures for timely consistent exchange of information and collaboration with LDH; • Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and • Provisions that comply with 42 CFR §438.608 and 438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.					
15.2.7	The MCO shall require and have procedures for a network provider to report to the MCO when it has received an overpayment, to return the overpayment to the MCO within sixty (60) calendar days of the date on which the overpayment was identified, and to notify the MCO in writing of the reason for the overpayment.	Overpayments Policy Overpayments notice form		Full	This requirement is addressed in the Program Integrity Provider Self-Audit.	
	The MCO shall have procedures for prompt reporting to the State of all overpayments identified and recovered, specifying the overpayments due to potential fraud.	Overpayments Policy		Full	This requirement is addressed in the 145 Report.	
15.3						
15.3.1	In accordance with 42 CFR 438.610, the MCO and its subcontractors are prohibited from knowingly having a relationship with: An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under regulations issued under Executive					

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	Order No. 12549 or under guidelines implementing Executive Order No. 12549.					
15.3.4	The MCO and its subcontractors shall comply with all applicable provisions of 42 CFR 438. 608 and 438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation.. The MCO and its subcontractors shall screen all employees and contractors and network providers to determine whether they have been excluded from participation in Medicare. Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, the MCO shall conduct screening to comply with the requirements set forth at 42 CFR 455.436.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 12.	
15.3.5	The MCO shall search the following websites: • Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE); • Louisiana Adverse Actions List Search; • The System of Award Management (SAM); and • Other applicable sites as may be determined by LDH	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 12.	
15.3.6	The MCO and its subcontractors shall conduct a search of these websites monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered should be reported to LDH within three (3) business days. Any individual or entity that employees or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This is a prohibited affiliation. This prohibition applies	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on pages 11 to 12.	

Fraud, Abuse, and Waste Prevention						
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	even when the Medicaid payment itself is made to another provider who is not excluded. For example, a pharmacy that fills a prescription written by an excluded provider for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR 1003.102(a)(2).					
15.3.6.1	An individual who is an affiliate of a prohibited person or entity described above include: • A director, officer, or partner of the MCO; • A subcontractor of the MCO; • A person with beneficial ownership of five (5%) percent or more of the MCO's equity; or • A person with an employment, consulting or other arrangement with the MCO for the provision of items and services which are significant and material to the MCO's obligations under this contract. • A network provider.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 11.	
15.3.6.2	The MCO shall notify LDH in writing within three (3) days of the time it receives notice that action is being taken against the MCO or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. 1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the MCO or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 12.	
15.3.7	The MCO, through its Contract Compliance	FWA Compliance Plan		Full	This requirement is addressed in the 148	

Fraud, Abuse, and Waste Prevention						
Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	Officer, shall attest monthly to LDH that a search of the websites referenced in 15.3.5 been completed to capture all exclusions.	Copies of monthly reports			Monthly Report.	
15.4						
15.4.1	Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for certain emergency services; and	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 11.	
15.4.2	The MCO is responsible for the return to the State of any money paid for services provided by an excluded provider.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 12.	
15.5						
15.5.1	The MCO and its subcontractors shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect to the state's Office of Attorney General MFCU, and LDH within three (3) business days of discovery, taking prompt corrective actions and cooperating with LDH in its investigation of the matter(s).	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 13.	
15.5.2	The MCO shall notify LDH within three (3) business days of the time it receives notice that action is being taken against the MCO or MCO employee, network providers, subcontractor or subcontractor employee or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. 1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the MCO, network provider or a subcontractor from the Medicaid or CHIP program, or any program listed in Executive Oder 12549.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 12.	
15.5.3	Reporting shall include, but is not limited to, as set forth in 42 CFR 455.17:					
15.5.3.1	Number of complaints of fraud, abuse, waste, neglect and overpayments made to the MCO that warrant preliminary investigation (under 42 CFR 455.14);	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 13.	

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15.5.3.2	Number of complaints reported to the Contract Compliance Officer; and	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 13.	
15.5.3.3	For each complaint that warrants full investigation (defined at 42 CFR 455.15 and 455.16, the MCO shall provide LDH, at a minimum, the following: • Provider name and ID number; • Source of complaint; • Type of complaint; • Nature of complaint; • Approximate range of dollars involved if applicable; and • Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 14.	
15.5.3	The MCO, through its compliance officer, shall attest to LDH that a search of websites referenced in Section 15.3.3 has been completed to capture all exclusions.	FWA Compliance Plan Attestation Form		Full	This requirement is addressed in 148 Monthly Report.	
15.5.4	The MCO shall report to LDH Program Integrity at least quarterly all audits performed and overpayments identified and recovered by the MCO and all of its subcontractors. [See 42 CFR §438.608(d)(3)] .	FWA Compliance Plan Copies of quarterly reports		Full	This requirement is addressed in the 145 Report.	
15.5.5	The MCO shall report all to LDH Program Integrity at least quarterly all unsolicited provider refunds, to include any payments submitted to the MCO and/or its subcontractors by providers for overpayments identified through self-audit and/or self-disclosure.	FWA Compliance Plan Copies of quarterly reports		Full	This requirement is addressed in the 145 Report.	
15.5.6	LDH shall utilize MCO overpayment and recovery data in calculating future capitation rates per 42 CFR §438.608(d)(4).					
15.6						
15.6.1	The MCO shall have a method to verify that services for which reimbursement was made, was	P/P for medical records P/P for medical record		Full	This requirement is addressed in the provider handbook on page 27 and the PCP	

Fraud, Abuse, and Waste Prevention						
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	provided to members as billed. The MCO shall have policies and procedures to maintain, or require MCO providers and contractors to maintain, an individual medical record for each member. The MCO shall ensure the medical record is:	documentation standards P/P for medical record monitoring Provider Manual Model Provider Contracts for all provider types			service agreement on page 5.	
15.6.1.1	Accurate and legible;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the provider handbook on page 27 and the PCP service agreement on page 5.	
15.6.1.2	Safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all members evaluated or treated, and is accessible for review and audit; and	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the provider handbook on page 27 and the PCP service agreement on page 5.	
15.6.1.3	Readily available for review and provides medical and other clinical data required for Quality and Utilization Management review.	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the provider handbook on page 27 and the PCP service agreement on page 5.	
15.6.2	The MCO shall ensure the medical record includes, minimally, the following:	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the provider handbook on page 27 and the PCP service agreement on page 5.	
15.6.2.1	Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the provider handbook on page 27 and the PCP service agreement on page 5.	
15.6.2.2	Primary language spoken by the member and any translation needs of the member;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the Provider Handbook on page 27 and the PCP service agreement on page 5.	
15.6.2.3	Services provided through the MCO, date of service, service site, and name of service provider;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the provider handbook on page 27 and the PCP service agreement on page 5.	
15.6.2.4	Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the MCO;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the provider handbook on page 27 and the PCP service agreement on page 5.	
15.6.2.5	Referrals including follow-up and outcome of referrals;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the provider handbook on page 27 and the PCP service agreement on page 5.	

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15.6.2.6	Documentation of emergency and/or after-hours encounters and follow-up;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the provider handbook on page 27 and the PCP service agreement on page 5.	
15.6.2.7	Signed and dated consent forms (as applicable);	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the provider handbook on page 27 and the PCP service agreement on page 5.	
15.6.2.8	Documentation of immunization status;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the provider handbook on page 27 and the PCP service agreement on page 5.	
15.6.2.9	Documentation of advance directives, as appropriate;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the provider handbook on page 27 and the PCP service agreement on page 5.	
15.6.2.10	Documentation of each visit must include: Date and begin and end times of service; Chief complaint or purpose of the visit; Diagnoses or medical impression; Objective findings; Patient assessment findings; Studies ordered and results of those studies (e.g. laboratory, x-ray, EKG); Medications prescribed; Health education provided; Name and credentials of the provider rendering services (e.g. MD, DO, OD) and the signature or initials of the provider; and Initials of providers must be identified with correlating signatures.	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the provider handbook on page 27 and the PCP service agreement on page 5.	
15.6.2.11	Documentation of EPSDT requirements including but not limited to: Comprehensive health history; Developmental history; Unclothed physical exam; Vision, hearing and dental screening; Appropriate immunizations; Appropriate lab testing including mandatory lead screening; and Health education and anticipatory guidance.	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the provider handbook on page 27 and the PCP service agreement on page 5.	
15.6.3	The MCO is required to provide one (1) free copy of any part of member's record upon member's request.	P/P for medical records		Full	This requirement is addressed in the provider handbook on page 134.	
15.6.4	All documentation and/or records maintained by the MCO its subcontractors, and all of its network	P/P for medical records P/P for medical record		Full	This requirement is addressed in the provider handbook on page 28 and the LA	

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	providers related to all services, charges, operations and agreements under this contract shall be maintained for at least ten (10) calendar years after the last good, service or supply has been provided to a member or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.	retention			Subcontractor Flowdown on page 14.	
15.7						
15.7.1	The MCO and its subcontractors is responsible for investigating and reporting possible acts of provider fraud, abuse, and waste for all services under this contract,.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 15.	
15.7.2	The MCO and its subcontractors shall have the right to audit and investigate providers and members within the MCO's network for a five (5) year period from the date of service of a claim. The collected funds from these reviews are to remain with the MCO. The MCO shall report to LDH on a quarterly basis the results of all reviews, and include instances of suspected fraud, identified overpayments, and collection status. Notice to the provider shall be prohibited in instances resulting from suspected fraud, which the MCO has identified and referred to the Department, MFCU, or other appropriate law enforcement agency, unless approved by LDH.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 15.	
15.7.3	All reviews shall be completed within eight months (240 calendar days) of the date the case was opened unless an extension is authorized by LDH. This review period is inclusive of all provider notifications, health plan document reviews, and includes any provider appeal or rebuttal process.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 15.	
15.7.4	The MCO shall confer with LDH before initiating a	FWA Compliance Plan		Full	This requirement is addressed in the	

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	post-payment provider-focused review to ensure that review and recovery is permissible. Notification of intent to review and/or recover shall include at a minimum: provider name, NPI, city and provider type, allegation or issue being reviewed, procedure codes or National Drug Codes (NDCs) under review, date range for dates of service under review, and amount paid. LDH shall respond within ten business days to each review notification. In the event LDH does not respond, the MCO may proceed with the review. The MCO and its subcontractors shall not pursue recovery until approved by LDH.				Compliance Program Description on page 15.	
15.7.5	Contact with the provider shall be prohibited in instances resulting from suspected fraud, which the MCO has identified and submitted a referral of fraud to the Department, MFCU, or other appropriate law enforcement agency, unless approved by LDH	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 16.	
15.7.6	If the MCO fails to collect at least a portion of an identified recovery after 365 days from the date of the Department approved proceeding with the recoupment (per 15.1.17), unless an extension or exception is authorized by the Department, or the MCO has documented recovery efforts deemed sufficient by LDH upon review, including formally initiating collection efforts, the Department or its agent may recover the overpayment from the MCO and said funds will be retained by the State. Exception reasons may include, but are not limited to, MCO cooperation with LDH or other government agencies, termination of provider participation with the MCO, or dissolution of the provider's business.					
15.7.7	LDH or its agent shall have the right to audit and investigate providers and members within the	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 15.	

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	MCO's network for a five (5) year period from the date of service of a claim. LDH may recover from the provider any overpayments identified by LDH or its agent, and said recovered funds will be retained by the State.					
15.7.8	LDH shall not initiate its own review on the same claims for a network provider which has been identified by the MCO as under a review approved by LDH per Section 15.7.4. LDH shall track open LDH and MCO reviews to ensure audit coordination. LDH shall not approve MCO requests to initiate reviews when the audit lead and timeframe is already under investigation by LDH or its agents.					
15.7.9	In the event LDH or its agent initiates a review on a network provider, a notification shall be sent to the MCO Special Investigation Unit (SIU) designee. The LDH notification of the intent to review shall include: provider name, NPI, city, and provider type, allegation or issue being reviewed, procedure codes or NDCs under review, date range for dates of service under review, and amount paid. The MCO shall have ten business days to indicate whether the claims were corrected or adjusted prior to the date of the notification from the Department. If the State does not receive a response from the MCO within ten business days, the State may proceed with its review.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 17.	
15.7.10	In the event the State or its agent investigates or audits a provider or member within the MCO's Network, the MCO shall comply with document and claims requests from the State within fourteen (14) calendar days of the request, unless another time period is agreed to by the MCO and State. Document requests do not include medical	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 17.	

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	records that shall be obtained from the provider.					
15.7.11	LDH shall notify the MCO and the network provider concurrently of overpayments identified by the State or its agents.					
15.7.12	The MCO shall not correct claims not initiate an audit on the claims upon notification of identified overpayment by the Department or its agent unless directed to do so by the Department.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 17.	
15.7.13	In the event the provider does not refund overpayments identified by the Department of its agent to the State, or arrange for an acceptable payment plan with the State, within thirty (30) calendar days of notification to the provider of the overpayment or where applicable, within thirty (30) calendar days of notification of the conclusion of the appeal process, the Department will notify the MCO and the MCO shall initiate a payment withhold on the provider in the amount due to the Department. Upon LDH request, the MCO shall refund to the State any amounts collected . Any instances of a credit balance would be sustained by the MCO and/or Department until resolved or dismissed under Department rules.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 15.	
15.7.14	In the event LDH or its agent recovers funds from a provider due to an overpayment, the MCO shall submit corrected encounter data within thirty (30) calendar days upon notification by LDH, and shall not seek additional recovery from the provider for the claims the LDH or its agent audited, unless approved by LDH.					
15.7.15	The MCO and its subcontractors shall enforce LDH directives regarding sanctions on MCO network providers and members, up to termination or exclusion from the network.	FWA Compliance Plan		Full	This requirement is addressed in the Excluded Provider Monitoring Policy and Procedure.	
15.7.11	There will be no LDH provider improper payment recovery request of the MCO applicable for dates	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 17.	

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	of service occurring before the start of the Medicaid Managed Care Contract period of for providers for which no MCO relationship existed.					
4.1.2	For the purposes of this contract, the MCO shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR §438.610(a) and (b), 42 CFR §1001.1901(b), 42 CFR §1003.102(a)(2)]. The MCO must screen all employees and sub-contractors to determine whether any of them have been excluded from participation in federal health care programs. The Health and Human Services-Office of Inspector General (HHS-OIG) website, which can be searched by the names of any individual, can be accessed at the following url: https://oig.hhs.gov/exclusions/index.asp.	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	This requirement is addressed in the Associate Guidebook on pages 46 to 47.	
4.1.4	The MCO shall comply with LDH Policy 8133-98, "Criminal History Records Check of Applicants and Employees," which requires criminal background checks to be performed on all employees of LDH contractors who have access to electronic protected health information on Medicaid applicants and recipients. It shall, upon request, provide LDH with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of this Contract.	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 12.	
4.2.1.6	Annually, the MCO must provide the name, Social	FWA Compliance Plan		Full	This requirement is addressed in the	

Fraud, Abuse, and Waste Prevention						
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	Security Number and date of birth of the staff members performing the duties of the key staff. LDH will compare this information against federal databases to confirm that those individuals have not been banned or debarred from participating in federal programs [42 CFR §455.104].				Compliance Program Description on page 14.	
7.6.2	The MCO shall not execute contracts with individuals or groups of providers who have been excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act [42 CFR §438.214(d)] or state funded health care programs. The list of providers excluded from federally funded health care programs can be found at http://exclusions.oig.hhs.gov/ and the System for Award Management, https://www.sam.gov/index.html/, and Health Integrity and Protection Data Bank at http://www.npdb-hipdb.hrsa.gov/index.jsp.	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	This requirement is addressed in Practitioner Contracts Policy and Procedure.	
7.13.6	The MCO shall not execute provider subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §1128 of the Social Security Act (42 U.S.C. §1320a-7) or §1156 of the Social Security Act (42 U.S.C. §1320c-5) or who are otherwise barred from participation in the Medicaid and/or Medicare program. The MCO shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	This requirement is addressed in the Compliance Program Description on page 12.	
9.5.5	The MCO shall not pay any claim submitted by a provider who is excluded or suspended from the Medicare, Medicaid or SCHIP programs for fraud,	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 12.	

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Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	abuse or waste or otherwise included on the Department of Health and Human Services Office of Inspector General exclusions list, or employs someone on this list. The MCO shall not pay any claim submitted by a provider that is on payment hold under the authority of LDH or its authorized agent(s).					
17.2.6.1.9	**Provider Validation –** Ensure that the system shall approve for payment only those claims received from providers eligible to render service for which the claim was submitted and that the provider has not been excluded from receiving Medicaid payments as stipulated in Section 9.4	FWA Compliance Plan		Full	This requirement is addressed in the Compliance Program Description on page 12.	
18.1	Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs (42 CFR §455.100-455.106.) The **Medicaid Ownership and Disclosure Form** (Appendix VV) is to be submitted to LDH with the proposal; then resubmitted prior to implementation for each Contract period, annually, and within thirty-five (35) days when any change in the MCO's management, ownership or control occurs.	FWA Compliance Plan		Full	This requirement is addressed in the Louisiana Medicaid Ownership Disclosure Information attached to the annual report.	
18.2	**Information Related to Business Transactions -** 18.2.1 The MCO shall furnish to LDH and/or to the HHS, information related to significant business transactions as set forth in 42 CFR §455.105. Failure to comply with this requirement may result in termination of this Contract. 18.2.2 The MCO shall submit, within thirty-five (35) days of a request made by LDH, full and complete information about: 18.2.2.1 The ownership of any subcontractor with whom the MCO has had business transactions	FWA Compliance Plan Provider Enrollment and Contract Forms		Not applicable		

Fraud, Abuse, and Waste Prevention						
Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	totaling more than $25,000 during the twelve (12) month period ending on the date of this request; and 18.2.3 Any significant business transactions between the MCO and any wholly owned supplier, or between the MCO and any subcontractor, during the five (5) year period ending on the date of this request. 18.2.4 For the purpose of this Contract, "significant business transactions" means any business transaction or series of transactions during any state fiscal year that exceed the $25,000 or five (5%) percent of the MCO's total operating expenses whichever is greater.					
18.3	**Report of Transactions with Parties in Interest –** 18.3.1 The MCO shall report to LDH all "transactions" with a "party in interest" (as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and SMM 2087.6(A-B)), as required by Section 1903(m)(4)(A) of the Social Security Act. 18.3.2 Federally qualified MCOs are exempt from this requirement. LDH may require that the information on business transactions be accompanied by a consolidated financial statement for the MCO and the party in interest. 18.3.3 If the MCO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. 18.3.4 The business transactions that must be reported are not limited to transactions related to	FWA Compliance Plan Provider Enrollment and Contract Forms		Not applicable		

Fraud, Abuse, and Waste Prevention						
Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	serving the Medicaid enrollment. All of the MCO's business transactions must be reported. 18.3.5 If the contract is renewed or extended, the MCO must disclose information on business transactions which occurred during the prior contract period.					
18.7	The MCO shall furnish LDH information related to any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as set forth in 42 CFR §455.106. Failure to comply with this requirement may lead to termination of this Contract.	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	This requirement is addressed in the Provider Handbook on pages 146 to 147.	
25.13.1	**Debarment, Suspension, Exclusion -** 25.13.1 The MCO agrees to comply with all applicable provisions of 2 CFR Part 376, pertaining to non-procurement debarment and/or suspension. As a condition of enrollment, the MCO must screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or all federal health care programs. To help make this determination, the MCO may search the following websites: • Office of Inspector General (OIG) List of Excluded Individuals/Entities) LEIE https://oig.hhs.gov/exclusions/index.asp; the Health Integrity and Protection Data Bank (HIPDB) • http://www.npdb-hipdb.hrsa.gov/index.jsp; • the Louisiana Adverse Actions List Search (LAALS), https://adverseactions.LDH.la.gov/; and/or • the System for Award Management,	FWA Compliance Plan		Full	This requirement is addressed in the Louisiana Medicaid Ownership Disclosure Information attached to the annual report.	

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

Fraud, Abuse, and Waste Prevention						
Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	Any amount expended for home health care services unless the MCO provides the appropriate surety bond.					

Reporting

Reporting						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.242)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
18.0	**Reporting**					
18.0	As per 42 CFR §438.242(a)(b)(1)-(3), the MCO shall maintain a health information system that collects, analyzes, integrates and reports data that complies with DHH and federal reporting requirements. The system must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and member disenrollment for reasons other than loss of Medicaid eligibility. The MCO shall collect data on member and provider characteristics and on services furnished to members.	Screen shot of health informatics system System reports		Full	This requirement is addressed in the Management Information Reports for 2018 and 2019 and in the Member Complaints and Grievances Report.	

D.7. Sample EPSDT Evaluation Tool

A sample EPSDT evaluation tool is provided following this page.

D.8. Sample EPSDT Evaluation Report

A sample EPSDT evaluation report is provided following this page.

D.9. Sample Network Adequacy Review Tool

A sample network adequacy review tool is provided following this page.

D.10. Sample Provider Information Validation Survey Tool

A sample provider information validation survey tool is provided following this page.

D.11. Sample Provider Information Validation Report

A sample provider information validation report is provided following this page.

D.12. Sample HEDIS Comparative Analysis Spreadsheet

A sample HEDIS comparative analysis spreadsheet is provided following this page.

D.13. Sample CAHPS Comparative Analysis Report Chapter

A sample CAHPS comparative analysis report chapter is provided following this page.

D.14. Sample PIP Report Template

A sample PIP report template is provided following this page.

D.15. Sample Annual Technical Report

A sample annual technical report is provided following this page.

Minnesota Department of Human Services
2019 External Quality Review Annual Technical Report
Issued April 29, 2021

An independent external quality review of Minnesota publicly funded managed care programs in accordance with the Balanced Budget Act of 1997 (Subpart E, 42 Code of Federal Regulations Section 438.364)

Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1002
(516) 326-7767
www.ipro.org

2019 External Quality Review
Annual Technical Report

Issued: April 29, 2021

Prepared by:
IPRO
1979 Marcus Avenue
Lake Success, NY 11042-1002
www.ipro.org

For More Information:
Mark Foresman, PhD, Supervisor, Quality Improvement
Division of Health Care Research and Quality
Health Care Administration
Minnesota Department of Human Services
P.O. Box 64986
P.O. Box 64986
St. Paul, MN 55164-0986
Telephone: (651) 431-6324
Fax: (651) 431-7422
E-mail: mark.foresman@state.mn.us

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ACRONYMS USED IN THIS REPORT

AACAP:	American Academy of Child and Adolescent Psychiatry
AAFP:	American Academy of Family Physicians
AAP:	American Academy of Pediatrics
ACA:	Affordable Care Act
ACC:	American College of Cardiology
ACCF:	American College of Cardiology Foundation
ACIP:	Advisory Committee on Immunization Practices
ACO:	Accountable Care Organization
ACOG:	American College of Obstetricians and Gynecologists
ACP:	American College of Physicians
ACPM:	American College of Preventive Medicine
ADA:	American Diabetes Association
AHA:	American Heart Association
AHRQ:	Agency for Healthcare Research and Quality
APA:	American Psychiatric Association
ASAM:	American Society of Addiction Medicine
ATR:	Annual Technical Report
BBA:	Balanced Budget Act (of 1997)
BOC:	Board of Commissioners
CAHPS:	Consumer Assessment of Healthcare Providers and Systems
CAP:	Corrective Action Plan
CBP:	County-Based Purchasing
CDC:	Centers for Disease Control and Prevention
CFR:	Code of Federal Regulation
CHW:	Community Health Worker
CLAS:	Culturally and Linguistically Appropriate Services
CMS:	Centers for Medicare and Medicaid Services
COPD:	Chronic Obstructive Pulmonary Disease
C&TC:	Child and Teen Checkups
DHS:	Department of Human Services, Minnesota
ED:	Emergency Department
EQR:	External Quality Review
EQRO:	External Quality Review Organization
ER:	Emergency Room
F&C-MA:	Families and Children Medical Assistance
GOLD:	Global Initiative for Chronic Obstructive Lung Disease
HEDIS®:	Healthcare Effectiveness Data and Information Set

HMO:	Health Maintenance Organization
HOS:	Medicare Health Outcomes Survey, HEDIS
HOS-M:	Medicare Health Outcomes survey – Modified, HEDIS
ICHHS:	Itasca County Health and Human Services
ICSI:	Institute for Clinical Systems Improvement
IMCare:	Itasca Medical Care
JACC:	Journal of the American College of Cardiology
JAMA:	Journal of the American Medical Association
JNC 8:	Eighth Joint National Committee
JPB:	Joint Powers Board
MA:	Medical Assistance
MBHO:	Managed Behavioral Health Organization, NCQA
MCO:	Managed Care Organization
MDH:	Minnesota Department of Health
MHCP:	Minnesota Health Care Programs
MIIC:	Minnesota Immunization Information Connection
MNCare:	MinnesotaCare
MNCM:	MN Community Measurement
MSHO:	Minnesota Senior Health Options
MSC+:	Minnesota Senior Care Plus
MTM:	Medication Therapy Management
MY:	Measurement Year
NCQA:	National Committee for Quality Assurance
NCU:	New Chronic User
NHLBI:	National Heart, Lung and Blood Institute
NIH:	National Institutes of Health
OB/GYN:	Obstetrician/Gynecologist
PBM:	Pharmacy Benefit Manager
PCP:	Primary Care Practitioner/Provider
PIP:	Performance Improvement Project
QA:	Quality Assurance
QAE:	Quality Assurance Examination
QC®	Quality Compass®
QI:	Quality Improvement
RY:	Reporting Year
SNBC:	Special Needs Basic Care
SNP:	Special Needs Plan
SOR:	State Opioid Response

SWA:	Statewide Average
TCA:	Triennial Compliance Assessment
UR:	Utilization Review
URI:	Upper Respiratory Infection
USDHHS:	United States Department of Health and Human Services
USPSTF:	United States Preventive Services Task Force
VBC:	Value-Based Contract
VBP:	Value-Based Program

EXECUTIVE SUMMARY

INTRODUCTION

The Balanced Budget Act (BBA) of 1997 established that state agencies contracting with managed care organizations (MCOs) provide for an annual external, independent review of the quality outcomes, timeliness of and access to the services included in the contract between the state agency and the MCO. *Title 42 Code of Federal Regulations (CFR) Section (§) 438.350 External quality review (a)* through *(f)* sets forth the requirements for the annual external quality review (EQR) of contracted MCOs. States are required to contract with an external quality review organization (EQRO) to perform an annual EQR for each contracted MCO. The states must further ensure that the EQRO has sufficient information to carry out this review, that the information be obtained from EQR-related activities and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicare and Medicaid Services[1] (CMS). Quality, as it pertains to an EQR, is defined in *Title 42 CFR § 438.320 Definitions* as "the degree to which an MCO, PIHP[2], PAHP[3], or PCCM[4] entity increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that is consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement."

Title 42 CFR § 438.364 External review results (*a)* through *(d)* requires that the annual EQR be summarized in a detailed technical report that aggregates, analyzes and evaluates information on the quality, timeliness and access to health care services that MCOs furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the MCOs regarding health care quality, timeliness and access, as well as make recommendations for improvement.

To comply with *Title 42 CFR Section § 438.364 External review results* (*a)* through *(d)* and *Title 42 CFR Section § 438.358 Activities related to external quality review*, the Minnesota Department of Human Services (DHS) has contracted with Island Peer Review Organization (IPRO), an EQRO, to conduct the annual EQR of the MCOs that comprised the Minnesota Health Care Programs (MHCP) in 2019.

MINNESOTA HEALTH CARE PROGRAMS

DHS purchases medical care coverage through contracts with these eight (8) MCOs: Blue Plus, HealthPartners, Hennepin Health, Itasca Medical Care (IMCare), Medica, PrimeWest Health, South Country Health Alliance (South Country), and UCare. These MCOs provide care through these five (5) Minnesota publicly funded managed care programs: Families & Children Medical Assistance (F&C-MA), MinnesotaCare (MNCare), Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), Special Needs Basic Care (SNBC).

[1] Centers for Medicare and Medicaid Services Website: https://www.cms.gov/
[2] Prepaid Inpatient Health Plan
[3] Prepaid Ambulatory Health Plan
[4] Primary Care Case Management

SCOPE OF EXTERNAL QUALITY REVIEW ACTIVITIES

This EQR technical report focuses on the federally mandated EQR activities and one optional EQR activity that were conducted in reporting year (RY) 2019. It should be noted that validation of provider network adequacy, though currently a standard in *Title 42 CFR § 438.358 Activities related to external quality review (b)(1)(iv)*, was not part of the *CMS External Quality Review (EQR) PROTOCOLS*[5] published in October 2019 and therefore not required for the 2019 EQR. These protocols also state that an "Information Systems Capabilities Assessment (ISCA) is a mandatory component of the EQR as part of Protocols 1, 2, 3, and 4." As set forth in *Title 42 CFR § 438.358 Activities related to external quality review (b)(1),* these activities are:

- ***CMS Mandatory Protocol 1*. Validation of Performance Improvement Projects (PIPs) –** DHS reviewed MCO PIPs to validate that the design, conduct and reporting aligned with *Title 42 CFR § 438.330(d)*, allowing real improvements in care and services and giving confidence in the reported improvements.
- ***CMS Mandatory Protocol 2.* Validation of Performance Measures** – IPRO reviewed the Healthcare Effectiveness Data and Information Set (HEDIS) audit results provided by the MCOs' National Committee for Quality Assurance (NCQA)-certified HEDIS compliance auditors, as well as MCO reported rates to determine compliance with the standards in *Title 42 CFR § 438.330(c)*.
- ***CMS Mandatory Protocol 3.* Review of Compliance with Medicaid and CHIP Managed Care Regulations –** DHS conducted a review of MCO policies and procedures, provider contracts and member files to determine MCO compliance with federal and state Medicaid requirements. Specifically, this review assessed compliance with the standards in *Title 42 CFR Part 438 Subpart D* and *Title 42 Part CFR § 438.330 Quality assessment and performance improvement program*.
- ***CMS Mandatory Protocol 4.* Validation of Provider Network Adequacy –** Not yet required, as protocols have not been published.
- ***CMS Optional Protocol 6.* Administration or Validation of Quality of Care Surveys –** DHS subcontracted with Health Services Advisory Group (HSAG), an NCQA-certified survey vendor to administer the 2019 Consumer Assessment of Healthcare Providers and Systems (CAHPS) to measure consumer satisfaction with the MHCP.

CMS defines *validation* in *Title 42 CFR § 438.320 Definitions* as "the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis."

The validation results of these EQR activities are in the **Conclusions** section that immediately follows.

While the *CMS External Quality Review (EQR) PROTOCOLS* published in October 2019 stated that an ISCA is a required component of the mandatory EQR activities, CMS later clarified that the systems reviews that are conducted as part of the National Committee for Quality Assurance (NCQA) Healthcare

[5] Medicaid.gov Website: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf

Effectiveness Data and Information Set (HEDIS®) Compliance Audit™ may be substituted for an ISCA. Findings from IPRO's review of the MCO's HEDIS final audit reports (FARs) are part of the performance measure-related sections of this report.

CONCLUSIONS

The DHS quality strategy aligns with CMS's requirements and provides a framework for MCOs to follow while aiming to achieve improvements in the quality of, timeliness of and access to care. In addition to conducting the required EQR activities, DHS's quality strategy includes state- and MCO-level activities that expand upon the tracking, monitoring and reporting of performance as it relates to the Medicaid service delivery system.

Validation of Performance Improvement Projects

DHS's validation of the 2019 MCO PIPs confirmed the state's compliance with the standards of *Title 42 CFR § 438.330(a)(1)*. The results of the validation activity determined that each MCO was compliant with the standards of *Title 42 CFR § 438.330(d)(2)*. PIP summaries and detailed validation results are in **Chapter 4** of this report.

Results show that rates of new chronic opioid users were slightly higher during the baseline period (2016/2017) than they are for 2018, indicating that fewer patients are ending up taking opioids for possibly dangerous amounts of time. All MCOs have experienced a drop in their New Chronic User rates. While the decrease in rates across the plans is a positive thing, it is important to note how the rates have become more similar to each other during this period. This might suggest that professional prescribing guidelines and clinical best practices are making their way successfully into the every-day practices of providers across the state, resulting in similar rates for the plans.

Validation of Performance Measures

IPRO's validation of the MCO 2019 performance measures confirmed the state's compliance with the standards of *Title 42 CFR § 438.330(a)(1)*. The results of the validation activity determined that each MCO was compliant with the standards of *Title 42 CFR § 438.330(c)(2)*.

IPRO reviewed each MCO's 2020 HEDIS MY 2019 final audit report (FAR) to determine its compliance with information systems (IS) standards. The FARs revealed that all MCOs met IS standards for the successful reporting of HEDIS. Detailed results of each MCOs FAR, as well as performance measure rates are in **Chapter 4** of this report.

MHCP HEDIS rate comparisons to national Medicaid benchmarks show that **access** to care for adults remains strong. The analysis also shows that opportunities to improve the **quality** of and **access** to care continue to exist for children and adolescents, women's health services, dental care for adults and children, and asthma medication management.

Review of Compliance with Medicaid and CHIP Managed Care Regulations

IPRO's review of the results of each MCO's most current Quality Assurance Exam (QAE) and Triennial Compliance Assessment (TCA) confirmed the state's compliance with evaluating MCO adherence to the standards in *Title 42 CFR Part 438 Subpart D* and *Title 42 CFR § 438.330.* All MCOs were compliant with these standards. Detailed results of each MCO's QAE and TCA are in **Chapter 4** of this report.

Although the MCOs were fully compliant with federal Medicaid standards, there remains an opportunity for MCOs to improve compliance with state Medicaid standards.

Administration or Validation of Quality of Care Studies

IPRO's review of the CAHPS report produced by HSAG, confirmed that the survey was conducted in alignment with CMS EQR *Protocol 6. Administration or Validation of Quality of Care Studies*. MCO-level performance is in section **Chapter 4** of this report.

MHCP CAHPS score comparison to national Medicaid benchmarks show that members continue to experience high levels of satisfaction with personal doctors and doctor communication. The analysis also shows that members continue to experience low levels of satisfaction with the overall health care received, specialist seen most often, and overall health plan service. Further, HSAG identified the following as key drivers for low member satisfaction: inability to get needed care as quickly as needed, MCO customer service not providing information or help as needed, and MCO forms being too difficult to complete.

RECOMMENDATIONS

Recommendations to the MCOs

MCO specific recommendations related to the **quality** of, **timeliness** of and **access** to care are in Section of **Chapter 4** of this report.

Recommendations to the Minnesota Department of Human Services

- Concerning the PIP, DHS should include intervention-tracking measures in the summary report to evaluate the effectiveness of the selected interventions.
- Although validation of network adequacy is not yet required, IPRO recommends that DHS monitor MCO adherence to Minnesota time and distance standards for Medicaid networks. The results of these monitoring activities may shed light on challenges members face with accessing care in a timely manner.
- Concerning the validation of performance measures, MetaStar recommends that:
    - DHS should continue to observe, address, and track data quality issues that may arise during data receipt from the MCO and to identify potential reporting bias or impact from known or potential issues.
    - DHS should continue to maintain numerators and denominators to allow for exact replication in future years. These could also be used to assess changes in technical specifications, National Drug Codes, and the impact of any additional encounters.

- DHS should continue to monitor the instances of members obtaining multiple identification numbers. It is a best practice to link multiple identification numbers with a single identifier, such as a Social Security Number.

CHAPTER 1: BACKGROUND

CMS requires that state agencies contract with an EQRO to conduct an annual EQR of the services provided by contracted Medicaid MCOs. This EQR must include an analysis and evaluation of aggregated information on the quality, timeliness, and accessibility of the health care services that an MCO furnishes to Medicaid recipients. Quality is defined in *Title 42 CFR § 438.320 Definitions* as *"the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics, through the provision of services consistent with current professional knowledge, and through interventions for performance improvement."*

To comply with these requirements, DHS contracted with IPRO to assess and report the impact of its Medicaid managed care program and each of the participating MCOs on the accessibility, timeliness, and quality of services. DHS requested that IPRO produce an aggregate technical report that evaluates, compares, and contrasts the MCO performance, as well as statewide performance. For comparative purposes, results for 2017 and 2018 are also displayed when available and appropriate. The framework for IPRO's assessment is based on the guidelines and protocols established by CMS, as well as state requirements.

DHS purchases medical care coverage through contracts with eight MCOs that receive a fixed, prospective monthly payment for each enrollee. The Minnesota Department of Health (MDH) licenses five of the entities as health maintenance organizations (HMOs): Blue Plus, HealthPartners, Medica, Hennepin Health, and UCare. These HMOs are non-profit corporations or government entities that provide comprehensive health maintenance services, or arrange for the provision of these services, to enrollees on the basis of a fixed prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee. The remaining three entities – Itasca Medical Care (IMCare), PrimeWest Health, and South Country Health Alliance (South Country) – are licensed as county-based purchasing (CBP) organizations. CBP organizations are health plans operated by a county or group of counties, which purchase health care services for certain residents enrolled in the Medical Assistance and MinnesotaCare programs.[6]

MINNESOTA'S PUBLICLY FUNDED MANAGED CARE PROGRAMS INCLUDE:

- **Families & Children Medical Assistance (F&C-MA):** A program for low-income people, low-income families with children, and children who are in need.
- **MinnesotaCare (MNCare):** A program for working families and people who do not have access to affordable health care coverage and meet certain income, asset, and residency requirements.
- **Minnesota Senior Health Options (MSHO):** A DHS program that combines Medicare and Medicaid financing and acute and long-term care service delivery systems for persons over 65 years of age who are dually eligible for both Medicare and Medicaid.

[6] https://www.health.state.mn.us/facilities/insurance/managedcare/planinfo/hmo.html

- **Minnesota Senior Care Plus (MSC+):** A mandatory program for individuals age 65 years and older who qualify for Medical Assistance (Medicaid).
- **Special Needs Basic Care (SNBC):** A voluntary program for individuals, ages 18 – 64 years, who are certified disabled and qualify for the Medical Assistance (Medicaid) program.

Table 1: MCO Participation by Program in 2019

MCO	F&C-MA	MNCare	MSHO	MSC+	SNBC
Blue Plus	●	●	●	●	
HealthPartners	●	●	●	●	●
Hennepin Health	●	●			●
IMCare	●	●	●	●	
Medica			●	●	●
PrimeWest Health	●	●	●	●	●
South Country	●	●	●	●	●
UCare	●	●	●	●	●

MCO-managed care organization; F&C-MA-Families & Children Medical Assistance; MNCare-MinnesotaCare; MSHO-Minnesota Senior Health Options; MSC+-Minnesota Senior Care Plus; SNBC-Special Needs Basic Care; IMCare-Itasca Medical Care; South Country-South Country Health Alliance.

The DHS-MCO contract specifies the relationships between the purchaser and the MCOs and explicitly states compliance requirements for finances, service delivery, and quality of care terms and conditions. DHS and the MCOs meet throughout the year to ensure ongoing communication between the purchaser and the MCOs and to discuss contract issues.

DHS contracts with IPRO to serve as its EQRO. As part of this agreement, IPRO performs an independent analysis of MCO performance relative to quality, access, and timeliness of health care services. This report is the result of IPRO's evaluation and review of activities in 2019.

The purpose of the 2019 ATR is to present the results of the quality evaluations performed in accordance with the BBA,[7] review the strengths and weaknesses of each MCO, provide recommendations for improvement, and provide technical assistance to the MCOs. This report provides insight into the performance of the MCOs on key indicators of health care quality for enrollees in publicly funded programs.

Forming the foundation for improving care for the populations served by DHS is the Quality Strategy. CMS requires that each state Medicaid agency has a written strategy for evaluating the quality of care of its publicly funded managed care programs. The DHS quality strategy operationalizes the theories and precepts influencing the purchase of managed health care services for publicly funded programs. The strategy is designed to assess the quality and appropriateness of care and service provided by MCOs for all managed care contracts, programs, and enrollees. It is aimed at achieving seven essential outcomes:

[7] Subpart E, 42 Code of Federal Regulations (CFR), Section 438.364

1. Purchasing quality health care services
2. Protecting the health care interests of managed care enrollees through monitoring
3. Assisting in the development of affordable health care
4. Reviewing and realigning DHS policy and procedures that act as unintended barriers to the effective and efficient delivery of health care services
5. Focusing on health care prevention and chronic disease improvements consistent with enrollee demographics and cultural needs
6. Improving the health care delivery system's capacity to deliver desired medical care outcomes though process standardization, improvement, and innovation
7. Strengthening the relationship between the patients and health care providers

Purchasing quality health care services is the primary outcome of the DHS quality strategy. To achieve this outcome, there must be measurement of improvement in enrollee health status and satisfaction. DHS's quality strategy is framed on the key standards in Subpart D of the Medicaid Managed Care Regulation *(Quality Assessment and Performance Improvement)*: Access, Structure and Operations, and Measurement and Improvement.

Minnesota Health Care Programs help eligible people pay for all, or some, medical bills. The programs are generally for people who cannot get or afford health insurance elsewhere. Some people who already have insurance may also be eligible for assistance. To obtain coverage, there are rules about income, assets, insurance coverage, and other factors. Some rules vary for different people; for example, the income limit depends on age, living situation, and pregnancy or disability status.

Within the State of Minnesota, publicly funded medical assistance is available for:

- Pregnant women
- Families and children
- Adults with disabilities
- Children with disabilities
- People 65 years or older
- Adults without children

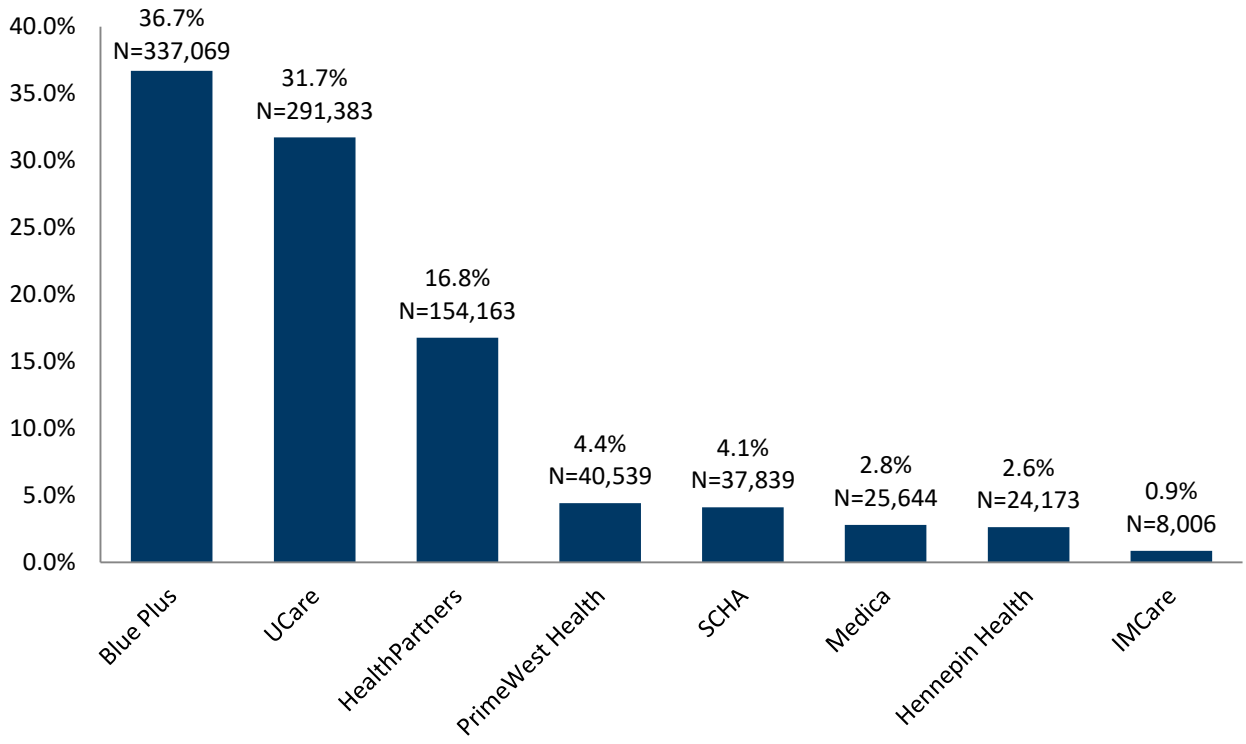
Coverage is also available for the following people who meet certain eligibility criteria:

- People who need nursing home care or home care
- Employed persons with disabilities
- People who want only family planning coverage
- People who have breast or cervical cancer and have been screened by the Sage Program[8]

[8] Please visit the Minnesota Department of Health SAGE Screening Program. https://www.health.state.mn.us/diseases/cancer/sage/index.html

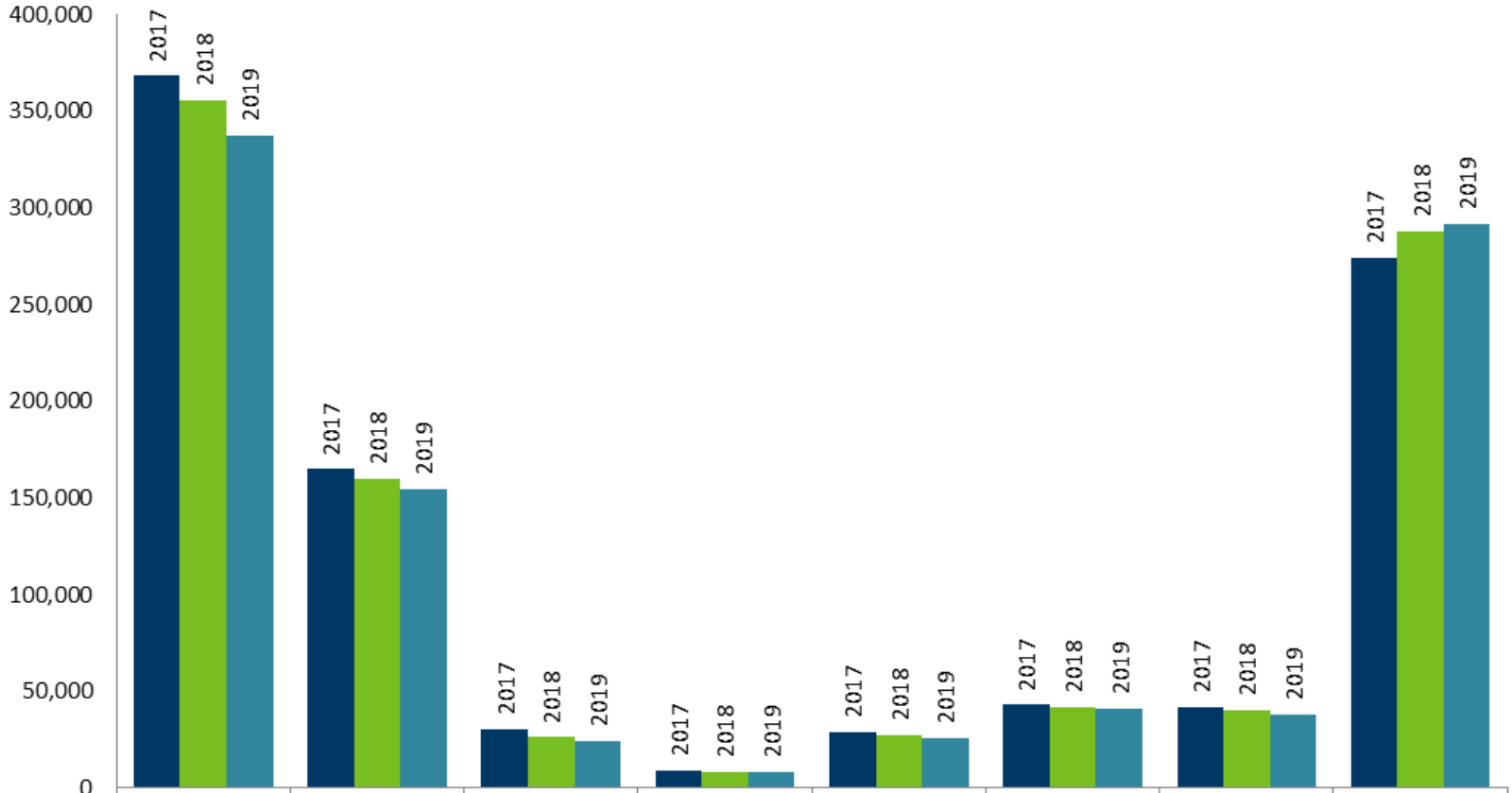
In December 2019, total enrollment for MHCP was 918,816; a 2.8% decrease since the December 2018 enrollment of 945,058.[9] **Figure 1** displays December 2019 MHCP enrollment by MCO while **Figure 2** trends MHCP enrollment for December 2017, December 2018 and December 2019.

Figure 1: MHCP Enrollment by MCO – December 2019



[9] Enrollment data presented in Chapters 1 and 3 of this report derive from the DHS Managed Care Enrollment Figures for December 2019. https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_141529

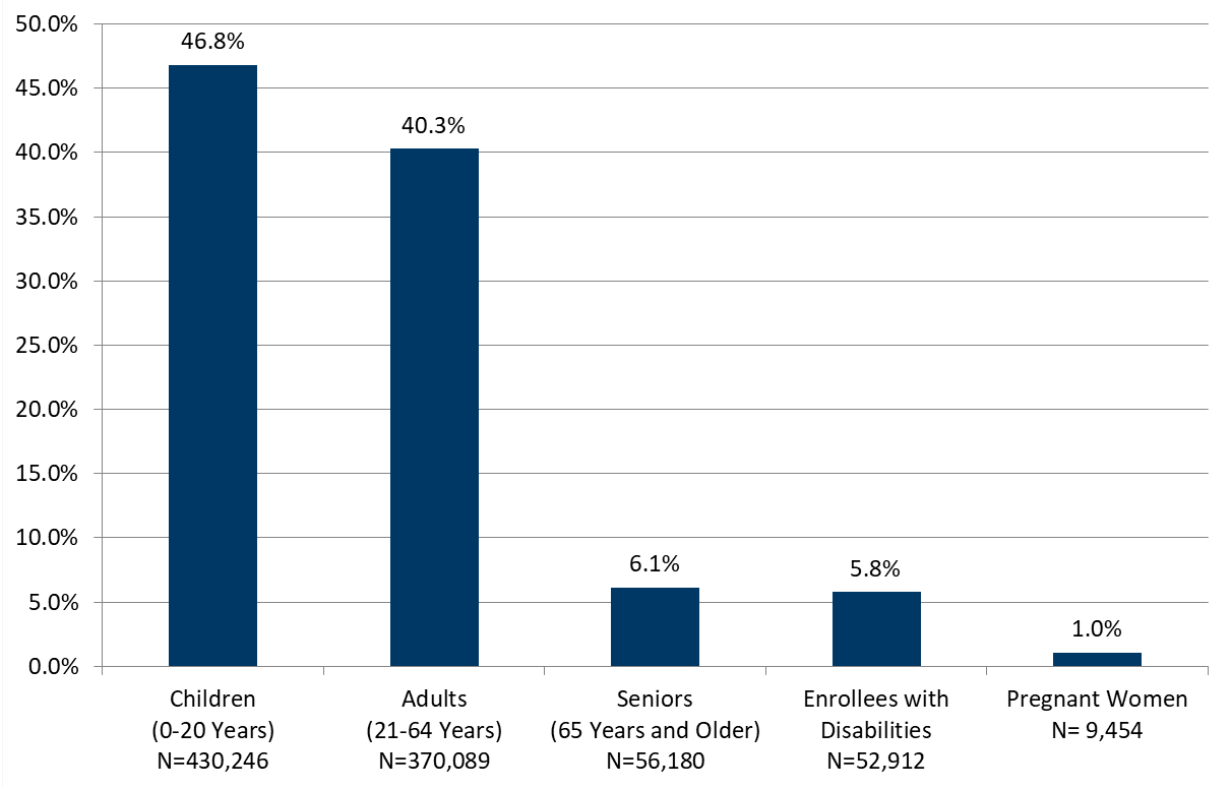
Figure 2: MHCP Enrollment Trends by MCO – December 2017, December 2018 and December 2019



	Blue Plus	HealthPartners	Hennepin Health	IMCare	Medica	PrimeWest Health	SCHA	UCare
2017 Enrollment	N=367,956	N=164,535	N=30,307	N= 8,922	N= 28,487	N=42,562	N= 41,704	N=273,811
2018 Enrollment	N=355,101	N=159,762	N=25,755	N= 8,162	N= 26,972	N=41,715	N= 40,184	N=287,407
2019 Enrollment	N=337,069	N=154,163	N=24,173	N= 8,006	N= 25,644	N=40,539	N= 37,839	N=291,383

As displayed in **Figure 3**, children are the largest population served by MHCP, accounting for almost 47% of the total enrollment. The overall December 2019 population breakdown is similar to that observed in December 2018.

Figure 3: Enrollment by Population Type – December 2019



2019 Minnesota Medicaid Quality Strategy

DHS aims to ensure access to quality health care for all Medicaid managed care enrollees and to work with enrollees, the state's EQRO, MCOs, providers and other state agencies, such as the MDH, to improve access, quality and continuity of care. DHS strives to achieve results in seven (7) essential outcomes through its Minnesota Medicaid Managed Care Comprehensive Quality Strategy:

- Purchasing quality health care services.
- Protecting the health care interests of managed care enrollees through monitoring of care and services.
- Assisting in the development of affordable health care.
- Reviewing and realigning any DHS policies and procedures that act as unintended barriers to the effective and efficient delivery of health care services.

- Focusing health care improvements on enrollee demographics and cultural needs.
- Improving the health care delivery system's capacity to deliver desired medical care outcomes though process standardization, improvement and innovation.
- Strengthening the relationship between patients and health care providers.

Accountability and transparency: As stewards of public funds, DHS holds MCOs accountable for the quality of the health care services provided. The quality strategy holds MCOs accountable through the use of consistent quality and performance measures reported to DHS, enrollees and the public. The measures review many aspects of care and service with a particular focus on the ability to obtain the greatest health improvement at the lowest cost, balanced by conformity with social and cultural preferences.

Value: The worth of services provided will be determined in relation to long-term health care outcomes and satisfaction of principal consumers, the managed care enrollees. The quality strategy evaluated findings to the question: "Did the delivery system provide care and services in the appropriate quantity, quality and timing to realize the maximum attainable health care improvement at the most advantageous balance between cost and benefit?"

Consumer informed choice and responsibility: The most effective and efficient health care delivery system includes the patient in the health care decision process. In order for patients to participate, they must be provided with the prerequisite health care information. Patients must also assume responsibility as informed consumers to make responsible choices and reduce high-risk behaviors in order to realize optimum outcomes. A measured, thoughtful, strategic and systematic patient-centered approach must be employed to achieve sustained improvement.

Key goals include:

- Achieve better health outcomes.
- Increase and support independence and recovery.
- Increase community integration.
- Reduce reliance on institutional care.
- Simplify the administration of the program and access to the program.
- Create a program that is more fiscally sustainable.
- Family planning program-specific:
    - Increase the number of Minnesotans who have access to family planning services through Minnesota Health Care Programs.
    - Increase the proportion of men and women enrolled in Minnesota Health Care Programs who utilize family planning services.
    - Increase the average age of mother at first birth among MHCP enrollees.
    - Reduce the teen birth rate among MHCP enrollees.

Key Activities and Programs Include:

- Technical and Regulatory Monitoring
- Performance Improvement Project

- Opioid Prescribing Improvement Program
- Integrated Care for High-Risk Pregnant Women
- Value-Based Payment Program
- Home- and Community-Based Services
- Nursing Home Quality
- Behavioral Health Homes Model
- Integrated Care System Partnerships
- Assessment of Consumer Satisfaction
- Managed Care Grievances Monitoring
- MCO Internal Quality Improvement System Review
- HEDIS Reporting

CHAPTER 2: SUMMARY OF DHS ACTIVITIES

2019 Minnesota Health Care Disparities Report

In 2020, DHS contributed to the production of the MN Community Measurement© *2019 Minnesota HealthCare Disparities by Insurance Type*[10]. The data presented in the report was collected in 2019 for 2018 dates of service. The report focuses on statewide results for nine (9) quality measures across three overarching areas of care by race and ethnicity. The nine (9) quality measures are:

Preventive Health

1. Breast Cancer Screening
2. Colorectal Cancer Screening
3. Child Immunization Status (Combo 10)

Chronic Conditions

4. Optimal Diabetes Care
5. Optimal Vascular Care
6. Optimal Asthma Control – Adult
7. Optimal Asthma Control – Children

Depression

8. Adult Depression Remission at Six Months
9. Adolescent Mental Health and/or Depression Screening

Key findings of the report include:

- Statewide MHCP results improved significantly since last year for six (6) measures: Colorectal Cancer Screening, Optimal Diabetes Care, Optimal Vascular Care, Optimal Asthma Control – Adults, Optimal Asthma Control – Children and Adolescent Mental Health and/or Depression Screening.
- Statewide MHCP rates are consistently and significantly lower than the Other Purchasers statewide rates for all nine (9) measures.
- American Indian/Alaskan Native patients were significantly *below* the MHCP statewide rate for eight (8) measures. This group did not perform significantly above any MHCP statewide rate.
- Black/African American patients were significantly *below* the MHCP statewide rate for seven (7) measures. This group did not perform significantly above any MHCP statewide rate.
- Asian patients were significantly *above* the MHCP statewide rate for two (2) measures. This group did not perform significantly below any MHCP statewide rate.

[10] 2019 Minnesota Heath Care Disparities by Insurance Type Report Website: https://www.lrl.mn.gov/docs/2020/mandated/200638.pdf

- White patients were significantly *above* the MHCP statewide rate for four (4) measures. This group did not perform significantly below any MHCP statewide rate.
- Multi-Racial patients were significantly *below* the MHCP statewide rate for three (3) measures. This group did not perform significantly above any MHCP statewide rate.
- Hispanic patients were significantly *above* the MHCP statewide rate for one (1) measure and were significantly below the MHCP statewide rate for one (1) measure.

State Response to the Opioid Crisis

State Targeted Response (STR) Grant (2017-2020)

In 2017, Minnesota received a two-year grant from the Substance Abuse and Mental Health Services Administration. The State Targeted Response (STR) to the Opioid Crisis Grant program expands access to evidence-based prevention, treatment, and recovery support services, reduces unmet treatment needs, and helps to prevent opioid overdose deaths. The grant was extended and expired on July 1, 2020.

The State used the STR funds to issue 40 grants to tribes, counties and community agencies. Grants were aimed at addressing the opioid crisis through prevention, increasing access to treatment and reducing opioid overdose related deaths. Grant awards were based on unmet need for opioid use disorder treatment and drug poisoning deaths.

The grants supplemented ongoing proven effective substance use disorder services, as well as offer new and innovative approaches. Grant activities included:

- Expanding access to naloxone—a drug that serves as an immediate life-saving antidote to opioid overdose—for opioid treatment programs and emergency medical service teams.
- Expanding medication assisted treatment, in both the number of providers and their geographic reach. Medication-assisted treatment combines behavioral therapy and medications to treat substance use disorders.
- Making it easier and faster for people to receive a substance use disorder for treatment services.
- Increasing opioid-specific peer recovery and care coordination.
- Piloting Parent Child Assistance Program, a peer support program for pre- and post-natal mothers.
- Launching “Fast-Tracker,” a website showing real-time treatment bed availability.

Medication Assisted Treatment for Prescription Drug and Opioid Addiction -Grant (2017-2021)

In the fall of 2017, Minnesota was awarded a $6 million, 3-year federal grant for MAT. This grant is an important step to solving the opioid epidemic that has had a devastating effect on too many individuals, families and communities.

The funds support efforts with the White Earth Nation, Red Lake Nation and Fairview Health Services. Two organizations were also funded to provide technical assistance and support.

The grant allows DHS to work to monitor the grants, make medication-assisted treatment more available and work to decrease disparities in Minnesota.

Minnesota received a one-year extension for this work until September 29, 2021.

State Opioid Response Grant (2018-2021)

In the fall of 2018, Minnesota was awarded the State Opioid Response (SOR) grant to provide $8,870,906 annually for the next two years. The grant has been used to reach Minnesotans struggling with opioids with life-saving treatment quickly, reduce deaths from opioid overdose and to prevent opioid use disorder in Minnesota's most vulnerable communities.

The funding was distributed through grants to Minnesota counties, tribes and community agencies to build on ongoing work, expand services to new areas, increase the availability of emergency response drugs such as Naloxone and launch new efforts to bring an end to the opioid crisis. Counties, tribes and community agencies will be able to apply for grants through an open process starting April 2021.

The SOR grant received an extension and runs through September 29, 2021.

State Opioid Response Supplemental Grant (2019-2021)

The federal government has also awarded Minnesota a supplemental grant of $4.26 million in July 2019.

This includes $775,000 in additional funding for Naloxone and support for ongoing work in prevention, clinician training and public awareness. In addition, grants will be provided for culturally responsive American Indian, African American and African-born opioid use disorder treatment programming, as well as other new initiatives, and a request for proposals has been issued.

As with the SOR grant, it received an extension and runs through September 29, 2021.

2019 Performance Measure Validation

The Minnesota Department of Human Services (DHS) elects to use standardized performance measures to assess quality of care and services provided by its contracted managed care organizations (MCOs). These measures are calculated from encounter data submitted by these organizations to DHS. In order to assure that specifications for these measures are followed, and that DHS' healthcare information system is capable of supporting such measures, DHS contracts with MetaStar for a rigorous assessment each year. This assessment meets CMS's performance measurement validation standards.

Findings

- Enrollment data processes remained stable. There was no evidence that enrollment data issues followed through to the encounter data reporting process for this project. DHS performed analysis on members identified with duplicate member numbers. Although, the numbers have not decreased from prior years, it was determined that only one percent of these members have active claims on a duplicate member number. DHS is currently working to manually remove the duplicate member numbers.

- A review of DHS rates showed no evidence that enrollment shifts negatively affected encounter data quality for 2019 reporting. Enrollment shifts were observed for the F&C-MA major program category. This is due to Medica discontinued providing services on May 1, 2017, which affected approximately 340,000 members. The impacted members were transitioned to other MN MCO's and did not meet continuous enrollment criteria in 2017, but did meet the criteria for 2018. An impact on continuous enrollment was identified for many measures due to this change.
- There was no evidence the integrity of the encounter data was compromised. Macro libraries were created to incorporate the codes in the value set directory. This practice decreases the potential for coding errors and increases the accuracy of the rates.
- There is no evidence that the processes of data extraction from DHS' mainframe databases into the DHS data warehouse introduces error that is not already present in the encounters as submitted.

CHAPTER 3: METHODOLOGY FOR THE EVALUATION OF STRENGTHS AND OPPORTUNITIES

To assess the impact of the MHCP on the **quality** of, **timeliness** of and **access** to health care services, IPRO considered MCO-level results from the EQR activities and a variety of sources including HEDIS compliance audit reports, accreditation reports, and quality assurance work plans. Specifically, IPRO considered the following elements during the 2019 external quality review:

- Performance Improvement Projects
- Performance Measures (including ISCA), HEDIS MY 2019 – Quality, Timeliness and Access
- Quality Assurance Examination and Triennial Compliance Assessment
- Quality of Care Survey, 2020 CAHPS – Member Satisfaction
- 2019 Financial Withhold

While not part of IPRO's evaluation, information on the following elements are also included in this report as they impact **quality**, **timelines** and **access**:

- MCO Annual Quality Assurance Work Plan for 2019
- MCO Evaluation of the 2019 Quality Assessment and Performance Improvement Program
- MCO Clinical Practice Guidelines

PERFORMANCE IMPROVEMENT PROJECTS

Minnesota MCOs are contractually required to conduct PIPs that meet the standards in *Title 42 CFR 438.330(d)* and the requirements of *Section 7.2.1* of the DHS model contract for MCOs. The PIPs must address clinical and non-clinical areas, and are expected to improve both enrollee health outcomes as well as enrollee satisfaction with their care and MCO. Starting in 2016, the DHS PIP reporting requirements were modified to resemble the Medicare format. PIPs run for three (3) years and follow BBA guidelines for PIP protocols.

The DHS model contract for 2018-2020 further required that MCO PIPs focus on preventing chronic opioid use and provide annual progress reports to DHS. These annual reports are used by the DHS Quality Improvement Team to validate MCO compliance with federal and state standards for PIP conduct. IPRO considered the results of the DHS validation activity during its evaluation of the MCOs.

Collaboratively, the MCO PIPs aimed to prevent patients who receive a new opioid prescription from staying on opioid drugs for long periods, especially if more effective pain management options are available and appropriate for the patient.

This project uses the New Chronic User (NCU) of Opioid Pain Relievers measure developed by DHS to monitor the success of the overall project. The NCU measure was developed to identify a clinically useful outcome measure that supports quality improvement efforts in preventing chronic opioid use. Minnesota Department of Human Services (DHS) has identified 45 days of opioid use as a critical timeline for patients as continued use beyond 45 days can result in long-term/chronic use or addiction.

The aim of this project is to decrease the number of F&C-MA, MNCare, MSHO, MSC+ and SNBC members who reach that 45-day threshold.

Common interventions across all MCOs included:

- Alignment of pharmacy practices
- Provider education
    - Provider toolkit
    - Webinar series
- Consistent messaging for community outreach
- Targeted clinical outreach

As this is the first reporting cycle looking back on the first year of the PIP, there is not sufficient information to draw specific conclusions.

An MCO meeting federal and state standards for PIPs was considered a strength during this evaluation. An MCO conducting a PIP that did not meet federal and state standards was considered an opportunity for improvement during this evaluation. MCO-level PIP summaries, PIP performance indicator rates and validation results are in **Chapter 5** of this report.

For information regarding activity objectives, technical methods of data collection and analysis, and description of data obtained see Appendix A.

Performance Measures

Information Systems Capabilities Assessment

The ISCA data collection tool allows the state or EQRO to evaluate the strength of each MCO's information system (IS) capabilities to meet the regulatory requirements for quality assessment and reporting. *Title 42 CFR § 438.242 Health information systems* and *Title 42 CFR § 457.1233 Structure and operation standards (d) Health information systems* also require the state to ensure that each MCO maintains a health information system that collects, analyzes, integrates, and reports data for purposes including utilization, claims, grievances and appeals, disenrollment for reasons other than loss of Medicaid or CHIP eligibility, rate setting, risk adjustment, quality measurement, value-based purchasing, program integrity, and policy development. While some portions of the ISCA are voluntary, there are some components that are required to support the execution of the mandatory EQR-related activities protocols.

While the *CMS External Quality Review (EQR) PROTOCOLS* published in October 2019 stated that an ISCA is a required component of the mandatory EQR activities, CMS later clarified that the systems reviews that are conducted as part of the HEDIS audit may be substituted for an ISCA.

Each MCO contracted with an NCQA-certified HEDIS compliance auditor for HEDIS MY 2019. Auditors assessed the MCO's compliance with NCQA standards in the following designated IS categories as part of the NCQA HEDIS MY 2019 Compliance Audit:

- **IS 1.0 Medicaid Services Data**: Sound Coding Methods and Data Capture, Transfer and Entry
- **IS 2.0 Enrollment Data**: Data Capture, Transfer and Entry
- **IS 3.0 Practitioner Data**: Data Capture, Transfer and Entry
- **IS 4.0 Medical Record Review Processes**: Training, Sampling, Abstraction and Oversight
- **IS 5.0 Supplemental Data**: Capture, Transfer and Entry
- **IS 6.0 Data Production Processing**: Transfer, Consolidation, Control Procedures that Support Measure Reporting Integrity
- **IS 7.0 Data Integration and Reporting**: Accurate Reporting, Control Procedures that Support Measure Reporting Integrity

An MCO meeting all IS standards required for successful HEDIS reporting and submitting HEDIS data to DHS according to the requirements in Medicaid model contract were considered strengths during this evaluation. An MCO not meeting an IS standard was considered an opportunity for improvement during this evaluation. MCO-level 2020 HEDIS MY 2019 compliance audit results are in **Chapter 5** of this report.

HEDIS Performance – Quality, Timeliness, and Access

HEDIS allows for the standardized measurement of care received. All of the performance measures reported herein are derived from HEDIS. For these measures, statewide averages and the most current national Medicaid benchmarks have been provided. HEDIS benchmarks originate from the National Committee for Quality Assurance (NCQA) 2020 *Quality Compass®*[11] for Medicaid and represent the performance of all MCOs (excluding PPOs and EPOs) that reported HEDIS data to the NCQA for MY 2019.

This report includes a combination of DHS-produced (administrative) and MCO-produced (hybrid) HEDIS rates in the ATR. Administrative rates were calculated using encounter data and were audited by DHS's NCQA-certified HEDIS compliance auditor, MetaStar. Hybrid rates were calculated using a mix of claims data and data abstracted from medical records, and were also validated by NCQA-certified HEDIS auditors. HEDIS rates produced by the MCOs were reported to the NCQA.

Due to the coronavirus disease of 2019 (COVID-19) outbreak and in accord with NCQA recommendations, DHS and MDH allowed Medicaid MCOs to request a waiver to report audited HEDIS MY 2018 hybrid rates if they were not able to complete HEDIS MY 2019 hybrid medical record chart reviews according to NCQA technical specifications.

Two (2) MCOs, IMCare and PrimeWest Health, elected not to apply for this waiver and reported rates for all of the required hybrid measures for HEDIS MY 2019. Hybrid rates for these two (2) MCOs are presented in their respective HEDIS data tables. Further, hybrid rates for two (2) HEDIS measures, Comprehensive *Diabetes Care-Eye Exam* and *Controlling High Blood Pressure,* were used in the assessment of IMCare and Prime West Health's strengths and opportunities.

[11] Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

To better identify MCO strengths and opportunities in this area, DHS continues to incorporate the measure matrix into the ATR. The measure matrix allows for the comparison of MCO performance year-over-year, as well as the comparison of MCO performance to the statewide average. It is a color-coded tool that visually indicates when an MCO's performance rates are notable or whether there is cause for action. For these year-over-year comparisons, the significance of the difference between two independent proportions was determined by calculating the z-ratio. A z-ratio is a statistical measure that quantifies the difference between two percentages when they come from two separate study populations.

As seen below, boxes in the top row indicate that there was a statistically significant positive change in the rate from 2018, boxes in the middle row indicate no change from 2018, while those in the bottom row indicate a statistically significant negative change in the rate. Similarly, boxes in the right column indicate that the rate for the measure is higher than the statewide average, with those in the middle column being the same as the statewide average, and those in the left column indicating a rate that is lower than the statewide average.

	Statewide Average Statistical Significance Comparison		
	Below Average	**Statewide Average**	**Above Average**
2018– 2019 Rate Change	**C**	**B**	**A**
	D	**C**	**B**
	F	**D**	**C**

The color of each box depends on its location in both the columns and rows and represents the recommended action:

The color of each box depends on its location in both the columns and rows and represents the recommended action:

The green box (or "A" box) indicates **notable performance**. The MCO's HEDIS MY 2019 rate is statistically significantly above the MY 2019 statewide average and trends up from HEDIS MY 2018.

The light green boxes (or "B" boxes) indicate a **potential opportunity for improvement, but no immediate action is required**. The MCO's HEDIS MY 2019 rate is not different than the MY 2019 statewide average and is statistically above the HEDIS MY 2018 rate or that the MCO's HEDIS MY 2018

rate is statistically significantly above the 2019 statewide average but there is no change from HEDIS MY 2018.

The yellow boxes (or "C" boxes) indicate that the **MCO should evaluate the measure for opportunities for improvement**. The MCO's HEDIS MY 2019 rate is statistically significantly below the MY 2019 statewide average and trends up from HEDIS MY 2018 or that the MCO's HEDIS MY 2019 rate is not different than the 2019 statewide average and there is no change from HEDIS MY 2018 or that the MCO's HEDIS MY 2019 rate is statistically significantly above the 2019 statewide average but trends down from HEDIS MY 2018.

The orange boxes (or "D" boxes) indicate **poor performance and action based on the results of a root cause analysis**. The MCO's HEDIS MY 2019 rate is statistically significantly below the MY 2019 statewide average and there is no change from HEDIS MY 2018 or that the MCO's HEDIS MY 2019 rate is not different than the 2019 statewide average and trends down from HEDIS MY 2018.

The red box (or "F" box) indicates **poor performance and action based on the results of a root cause analysis**. The MCO's HEDIS MY 2019 rate is statistically significantly below the MY 2019 statewide average and trends down from HEDIS MY 2018.

Measures selected for inclusion in the measure matrix cover four (4) overarching areas of care: oral care, chronic conditions, women's health, and child and adolescent care. Measures selected for these categories include:

- Oral Care
  - *Annual Dental Visit for Children*
  - *Annual Dental Visit for Adults*
- Chronic Conditions
  - HEDIS *Comprehensive Diabetes Care: HbA1c Test*
  - HEDIS *Controlling High Blood Pressure* (only for IMCare and PrimeWest Health)
  - HEDIS *Comprehensive Diabetes Care: Eye Exam* (only for IMCare and PrimeWest Health)
- Women's Preventive Care
  - HEDIS *Breast Cancer Screening*
  - HEDIS *Cervical Cancer Screening*
  - HEDIS *Chlamydia Screening in Women*
- Child and Adolescent Care
  - HEDIS *Adolescent Well-Care Visits*
  - HEDIS *Childhood Immunization Status: Combo 3*
  - HEDIS *Well-Child Visits in the First 15 Months of Life (6+ Visits)*
  - HEDIS *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life*

An MCO HEDIS rate achieving placement in the green box (or "A" box) of the matrix was considered a strength during this evaluation. An MCO HEDIS rate achieving placement in the orange boxes (or "D"

boxes) or red box (or "F" box) was considered an opportunity for improvement during this evaluation. MCO-level HEDIS MY 2019 rates and populated performance measure matrix are in **Chapter 5** of this report.

For information regarding activity objectives, technical methods of data collection and analysis, and description of data obtained see **Appendix B**.

Quality Assurance Examination and Triennial Compliance Assessment

Title 42 CFR § 438.358 Activities related to external quality review (b)(1)((iii) states that a review of an MCO's compliance with requirements established by DHS to comply with the standards of *Title 42 Part 438 Managed Care Subpart D* and the standards of *Title 42 CFR § 438.330* is a mandatory activity. Further, the state, its agent, or the EQRO must conduct this review within the previous three (3)-year period.

To comply with these requirements, DHS conducts the QAE and TCA to determine MCO compliance with requirements related to access to care, structure and operations, and quality measurement and improvement. The QAE assesses MCO compliance with state requirements while the TCA assesses MCO compliance with federal standards in *Title 42 Part 438 Managed Care Subpart D* and *Title 42 CFR § 438.330*.

While the QAE and TCA are conducted every three (3) years, the process is staggered and is conducted at different times for each MCO. A summary of recommendations, mandatory improvements and deficiencies from the *most recent* exam are presented for each MCO and was considered during IPRO's evaluation of the MCO. Recommendations are areas where, although compliant with law, opportunities for improvement were identified. The MCO submits a corrective action plan (CAP) to correct 'not-met' determinations, if necessary. If the MCO fails to submit a CAP within 30 days, and/or address contractual obligation compliance failures, then financial penalties will be assessed. Deficiencies are violations of law.

An MCO achieving full compliance with the QAE and/or TCA was considered a strength during this evaluation. An MCO receiving a "not met" determination was considered an opportunity for improvement during this evaluation. MCO-level HEDIS MY 2019 rates and populated performance measure matrix are in **Chapter 5** of this report.

For information regarding activity objectives, technical methods of data collection and analysis, and description of data obtained see **Appendix C** of this report.

Administration or Validation of CAHPS Quality of Care Survey

Member Satisfaction

DHS sponsors a member experience survey every year for adults enrolled in a Minnesota MCO. The results of this survey are used to determine variation in member satisfaction among the MCOs. CAHPS

allows for the standardized measurement of member satisfaction regarding healthcare services received.

DHS contracted with Health Services Advisory Group (HSAG), an NCQA-certified survey vendor, to conduct the 2019 CAHPS 5.0H Adult Medicaid Survey on behalf of the MCOs who offer F&C-MA, MNCare, MSC+ and SNBC.

In the CAHPS tables that follow, 2020 scores for the following composite measures were calculated In the CAHPS tables that follow, 2020 scores were calculated in the following ways:

- Composite measures were calculated using responses of "usually," "always" or "yes".
  - *Getting Needed Care*
  - *Getting Care Quickly*
  - *How Well Doctors Communicate*
  - *Customer Service*
  - *Shared Decision Making*
- Rating measures were calculated using responses of "9" or "10".
  - *Rating of All Health Care*
  - *Rating of Personal Doctor*
  - *Rating of Specialist Seen Most Often*
  - *Rating of Health Plan*

Historical data for 2018 and 2019 were recalculated using this scoring methodology as well. Statewide averages and national Medicaid benchmarks are provided for these measures. National Medicaid benchmarks originate from the NCQA 2020 *Quality Compass* and represent the performance of all health plans that reported CAHPS® data to the NCQA for HEDIS MY 2019.

An MCO score significantly higher than the statewide average (indicated by ▲) was considered a strength during the evaluation while a score significantly lower than the statewide average (indicated by ▼) was considered an opportunity for improvement. MCO-level 2020 CAHPS scores for MY 2019 are in **Chapter 5** of this report.

For information regarding activity objectives, technical methods of data collection and analysis, and description of data obtained see **Appendix D**.

2019 Financial Withhold

The overall purpose of the financial withhold is to emphasize and focus MCO and health care provider improvement efforts in the areas of prevention or early detection and screening of essential health care services. Specifically, the DHS-MCO contract allows DHS to withhold a percentage of the capitation payments due to the MCO, only to be returned if the MCO meets performance targets determined by the state.

An MCO achieving full points for a program was considered a strength during this evaluation. An MCO achieving less than full points for program was considered an opportunity for improvement during this evaluation. MCO-level performance for the 2019 financial withhold are in **Chapter 5** of this report.

MCO Annual Quality Assurance Work Plan for 2019

Each MCO submits an annual written work plan that details proposed quality assurance and performance improvement projects for the year. At a minimum, the work plan must present a detailed description of the proposed quality evaluation activities, including proposed focused studies, and their respective timetables for completion.

MCO-level summaries of the 2019 annual quality assurance work plans are in **Chapter 5** of this report.

MCO Evaluation of the 2019 Quality Assessment and Performance Improvement Program

Each MCO conducts an annual quality assessment and performance improvement program evaluation consistent with state requirements, federal regulations, and current NCQA *Health Plan Accreditation* standards. The evaluation reviews the impact and effectiveness of the MCO's quality assessment and performance improvement program, including performance on standard measures and performance improvement projects. Summaries of each MCO's annual quality assessment and performance improvement program evaluation follow; however, these reports were not evaluated as part of the EQR.

MCO-level summaries of the evaluation of the 2019 annual quality assurance work plan are in **Chapter 5** of this report.

MCO Clinical Practice Guidelines

MCOs are required to adopt, disseminate, and apply practice guidelines consistent with current NCQA *Health Plan Accreditation Requirements – Practice Guidelines (QI 9)*. Adopted guidelines should be:

- Based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field
- Reflective of the needs of the MCO's enrollees
- Adopted in consultation with contracting health care professionals
- Reviewed and updated periodically as appropriate
- Disseminated to all affected providers and, upon request, to enrollees and potential enrollees
- Applied to decisions for utilization management, enrollee education, coverage of services, and other areas to which there is application and consistency with the guidelines

MCO-level summaries adopted clinical practice guidelines are in **Chapter 5** of this report.

MCO Quality Improvement Program Websites

Each MCO submits annual quality program updates to demonstrate how their quality improvement programs identify, monitor and work to improve service and clinical quality issues related to MHCP enrollees. These updates are publicly presented on each MCO's corresponding website and highlight what the MCO considers to be significant quality improvement activities that have resulted in measurable, meaningful and sustained improvement. Additionally, the MCOs' most recent quality assurance work plan and evaluation of the quality assessment and performance improvement program can be accessed on these websites.[12] DHS Quality Improvement Team evaluates these websites for content and accessibility and provides feedback to MCOs with recommendations and required changes.

Summaries of the MCO websites are in **Chapter 5** of this report.

[12] MN DHS Managed Care: Quality, Outcome and Performance Measures Website: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/quality.jsp

CHAPTER 4: MCO-LEVEL FINDINGS AND RECOMMENDATIONS

This section of the report discusses MCO-level results, or findings, from the required EQR activities (validation of PIPs, validation of performance measures, and review of compliance with Medicaid standards) and one optional EQR activity; as well as strengths and recommendations related to the **quality** of, **timeliness** of and **access** to care. These three elements are defined as:

- ***Quality*** is the extent to which an MCO increases the likelihood of desired health outcomes for enrollees through its structural and operational characteristics and through health care services provided, which are consistent with current professional knowledge.
- ***Access*** is the timely use of personal health services to achieve the best possible health outcomes.[13]
- ***Timeliness*** is the extent to which care and services, are provided within the periods required by the Minnesota model contract with MCOs, federal regulations, and as recommended by professional organizations and other evidence-based guidelines.

[13]Institute of Medicine, Committee on Monitoring Access to Personal Health Care Services. Access to health care in America. Washington, DC: National Academy Press; 1993. https://www.ncbi.nlm.nih.gov/books/NBK235882/

BLUE PLUS

CORPORATE PROFILE

Blue Plus, a wholly owned subsidiary of Blue Cross and Blue Shield of Minnesota, is a licensed HMO. Blue Plus contracts with DHS to deliver and administer F&C-MA, MNCare, MSC+ and MSHO programs and healthcare services. Blue Plus has provided managed care coverage for MHCP members since 1993. Blue Plus maintains a Commendable level of accreditation by NCQA under the Health Plan Accreditation status for its Medicaid lines of business. As of December 2019, the enrollment totaled 337,069. This accounted for 36.7% of the entire MHCP population. **Table 2** displays the enrollment total of Blue Plus in December 2019.

Table 2: Blue Plus Enrollment as of December 2019

Program	Enrollment (as of December 2019)
F&C-MA	306,484
MNCare	30,585
MSC+	3,254
MSHO	8,508
Total Enrollment	**337,069**

Source= Minnesota Health Care Enrollment Totals December 2019 Report

QUALITY ASSURANCE EXAMINATION AND TRIENNIAL COMPLIANCE ASSESSMENT

In 2018, MDH conducted the most recent QAE and TCA on October 8, 2018 through October 12, 2018. The examination period covered December 1, 2015 to July 1, 2018, while the file review period covered July 1, 2017 to June 30, 2018. During this assessment, Blue Plus received a total of one (1) recommendation, five (5) mandatory improvements, and two (2) deficiencies for the QAE. The MCO received a total of three (3) "not met" designations for the TCA. However, the results of the TCA also concluded that Blue Plus was compliant with the standards of *Title 42 CFR Part 438 Managed Care Subpart D* and *Title 42 CFR § 438.330*. **Table 3** presents a summary of the TCA findings by the federal standards.

Table 3: Blue Plus Compliance Review Results for Part 438 Subpart D and QAPI Standards

Title 42 CFR 438 Subpart D and Title 42 CFR § 438.330	Review Determination (Met or Not Met)
Access Standards 438.206 Availability of Services 438.207 Assurances of Adequate Capacity and Services 438.208 Coordination and Continuity of Care 438.210 Coverage and Authorization of Service	Met
Structure and Operations Standards 438.214 Provider Selection 438.224 Confidentiality and Accuracy of Enrollee Records 438.228 Grievance Systems 438.230 Sub Contractual Relationships and Delegation	Met
Measurement Improvement Standards 438.236 Practice Guidelines Program 438.242 Health Information System	Met
Written Quality Assurance Plan (Quality Program Description) 438.330 Quality Assessment and Performance Improvement Program	Met
CFR= code of federal regulations	

PERFORMANCE IMPROVEMENT PROJECT

DHS's validation of Blue Plus's 2019 PIP confirmed its compliance with the standards of *Title 42 CFR 438.330(d)* and *Section 7.2* of the DHS model contract for MCOs.

In 2019, Blue Plus provided prescribers with individualized reports, to assist providers in better understanding patient prescribing habits. These reports included data to the prescribing physician in the context of Minnesota Opioid Prescribing Guidelines[14] and the goals of the PIP. Additionally, Blue Plus referred certain senior recipients into their medication therapy management (MTM) Program. This allowed Blue Plus to track the completion of member opioid therapy, identify patients who did not go on to receive another opioid prescription, and track seniors accessing alternative therapies for pain management.

Table 4 presents 2017-2019 new chronic user rates for Blue Plus and the state. As this is the first reporting cycle looking back on the first year of the PIP, there is not sufficient information to draw specific conclusions.

[14] MN Opioid Prescribing Guidelines, 2018: https://mn.gov/dhs/assets/mn-opioid-prescribing-guidelines_tcm1053-337012.pdf

Table 4: Blue Plus PIP Rates – New Chronic Users

Reporting Year	Blue Plus Rate	Statewide Average Rate
F&C-MA and MNCare		
2017 (baseline)	3.5%	3.5%
2018 (intervention year 1)	2.8%	2.7%
2019 (intervention year 2)	2.3%	2.1%
MSHO and MSC+		
2017 (baseline)	20.7%	18.5%
2018 (intervention year 1)	21.4%	22.9%
2019 (intervention year 2)	18.0%	14.9%

PIP=performance improvement project.

Table 5 displays validations results for the Blue Plus PIP.

Table 5: Blue Plus PIP Validation Results

PIP Validation Elements	Validation Results
Selected Topic	Met
Study Question	Met
Indicators	Met
Population	Met
Sampling Methods	Met
Data Collection Procedures	Met
Interpretation of Study Results	Met
Improvement Strategies	Met

PIP= performance improvement project.

2019 Financial Withhold

Blue Plus achieved 3.86 points (of 100 points) for the F&C-MA and MNCare programs, and achieved 75.76 points (of 90 points) for the MSHO and MSC+ programs. **Table 6** displays the results of the 2019 Financial Withhold, including performance measures, point values, and points earned by Blue Plus.

Table 6: Blue Plus 2019 Financial Withhold

Performance Measure	Point Value	Points Earned
F&C-MA and MNCare		
Annual Dental Visit: Age stratification 1-20 years	55	0
Annual Dental Visit: Age stratification 21-64 years	30	0
Provider Network Equity: FFS vs. MCO	10	0
Repeat Deficiencies on the MDH QAE	2	2
Emergency Department Utilization Rate	1	0.11
Hospital Admission Rate	1	1
Hospital 30-Day Readmission Rate	1	0.75
TOTAL	**100**	**3.86**
MSHO and MSC+		
Repeat Deficiencies on the MDH QAE	15	15
Care Plan Audit	15	15
Initial Health Risk Screening/Assessment	30	30
Stakeholder Group Reporting	15	15
Annual Dental Visit: Age 65+	15	0.76
TOTAL	**90**	**75.76**

FFS= fee-for-service; MCO= managed care organization;
QAE= Quality Assurance Exam.

Annual Quality Assurance Work Plan for 2019

Blue Plus developed a quality assurance work plan compliant with Minnesota Administrative Rule 4685.1130. To evaluate and implement strategies to improve the quality of care delivered to their members, data is collected and analyzed from multiple sources, committees are comprised of leaders and subject matter experts, the appropriate execution of delegation oversight is ensured, and operational reports are reviewed by the Care Management Committee. Collaborative activities included reducing chronic opioid use, improving health literacy, supporting provider quality initiatives, launching the Healthy Together Willmar initiative and continuing a partnership with the Minnesota Council of Health Plans. Blue Plus also monitors and improves the quality of behavioral health care and services by partnering with Magellan Health, a NCQA accredited Managed Behavioral Health Organization (MBHO), to perform behavioral health services. Quality clinical care is ensured via their member safety endeavors and their partnership with pharmacy benefit managers (PBM) and Prime to monitor medication use. Development activities designated to meet the requirements prescribed by either CMS, MDH and/or DHS, focused on tele-health awareness, web services enhancements, comprehensive diabetes care in the senior population, best practices for continuity and coordination of care, reducing chronic opioid use, utilization management, statin use, pump inhibitor duration, pharmacy drug safety, expansion of pharmacist services, member experience, mobile application, MTM participation, hypertension management, behavioral health, ADHD, colorectal cancer screenings, chlamydia and flu shot adherence.

Evaluation of the 2019 Annual Quality Assessment and Performance Improvement Program

In 2019, organizational restructuring and staffing changes were made regarding medical affairs, clinical quality improvement, quality management, vendor management office and individual staff. In 2019, Blue Plus also worked to assess program effectiveness by focusing on health plan accreditation, Medicare star ratings, resource adequacy, leadership involvement, quality management staff, clinical quality staff, organizational support, committee involvement, and physician involvement.. Improvements in clinical outcomes were achieved in 2019, yet there are opportunities to improve in the areas of chronic disease management and behavioral health. Of the forty-three (43) measures considered, nine met the listed goal and five measures scored just below their listed goal. Review of the 2018 results show a general decline across most of the Access to Care CAHPS results and the ECHO survey results. Successful quality activities include the value-based contract (VBC) care to address rising health care costs activity and to reduce clinical inefficiency and improve quality of care activity, given that all four (4) performance goals scored equal to or better than plan performance targets overall.

Clinical Practice Guidelines

Blue Plus recognizes the following sources for clinical practice guidelines:

- U.S. Preventive Services Task Force (USPSTF)[15]
  - Preventive services for adults
  - Preventive services for children and adolescents
  - Routine prenatal care
- Institute for Clinical Systems Improvement (ICSI)[16]
  - Treatment of individuals with major depressive disorder
- American Psychiatric Association (APA)[17]
  - Treatment of individuals with major depressive disorder
  - Diagnosis, evaluation, and treatment of ADHD in Children and Adolescents
- American Diabetes Association (ADA)[18]
  - Prevention and management of diabetes
- National Heart, Lung and Blood Institute (NHLBI)[19]
  - Diagnosis and management of asthma
- American Heart Association (AHA)
  - Management of Heart Failure
- National Osteoporosis Foundation (NOF)

[15] U.S. Preventive Services Task Force Website: https://uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P
[16] ICSI Guidelines Website: https://www.icsi.org/guidelines/
[17] American Psychiatric Association Website: https://www.psychiatry.org/
[18] American Diabetes Association Website: https://care.diabetesjournals.org/content/38/Supplement_1
[19] National Heart, Lung and Blood Institute Website: https://www.nhlbi.nih.gov/

    - Prevention and treatment of osteoporosis
- National Comprehensive Cancer Network (NCCN)[20]
    - Prevention and treatment of cancer
- National Hospice and Palliative Care Organization (NHCPCO)[21]
    - Process for reaching end-of-life decisions

In addition to the sources above, Blue Plus health coaches are also encouraged to utilize the following sources and materials for care management:

- Official government websites (.gov)
- Healthwise coaching materials[22]
- Medscape[23]
- National Institute of Health (NIH)[24]
- Centers for Disease Control and Prevention (CDC)[25]
- Case Management Society of America[26]
- PubMed[27]

Quality Improvement Program Website[28]

On the Quality Improvement Program Website, Blue Plus describes its quality program and evaluation results. Blue Plus identified the following program goals:

1) Improve member care, service, access and/or safety;
2) Improve service to providers, employers and other customers; and
3) Improve internal business processes.

To analyze care, Blue Plus considered the following areas:

- member access to network providers
- member feedback
- continuity and coordination of care
- population health management
- network provider feedback
- oversight

[20] National Comprehensive Cancer Network Website: https://www.nccn.org/
[21] National Hospice and Palliative Care Organization Website: https://www.nhpco.org/patients-and-caregivers/
[22] Healthwise Website: https://www.healthwise.org/
[23] Medscape Website: https://www.medscape.org/
[24] National Institutes of Health Website: https://www.nih.gov/
[25] Centers for Disease Control and Prevention Website: https://www.cdc.gov/
[26] Case Management Society of America Website: https://cmsa.org/
[27] National Library of Medicine PubMed Website: https://pubmed.ncbi.nlm.nih.gov/
[28] Blue Plus Quality Improvement Program Website: https://www.bluecrossmn.com/about-us/quality-improvement-program

Specific QI focuses included improving diabetes care; increasing colorectal cancer screenings; increasing chlamydia screenings; improving depression medication management; reducing opioid use.

Performance Measures

Information Systems Capabilities Assessment

The 2020 HEDIS FAR for MY 2019 produced by Attest Health Care Advisors indicated that Blue Plus met all of the requirements to successfully report HEDIS data to DHS. **Table 7** displays the results of the IS audit.

Table 7: Blue Plus Compliance with Information System Standards

Information System Standard	Review Result
1.0 Medical Services Data	Met
2.0 Enrollment Data	Met
3.0 Practitioner Data	Met
4.0 Medical Record Review Processes	Met
5.0 Supplemental Data	Met
6.0 Data Preproduction Processing	Met
7.0 Data Integration and Reporting	Met

HEDIS – Quality, Timeliness and Access

Due to the coronavirus disease of 2019 (COVID-19) outbreak and in accord with NCQA recommendations, DHS and MDH allowed Medicaid MCOs to request a waiver to report audited HEDIS MY 2018 hybrid rates if they were not able to complete HEDIS MY 2019 hybrid medical record chart reviews according to NCQA technical specifications. .

Blue Plus's waiver to report HEDIS MY 2018 hybrid rates for HEDIS MY 2019 was approved. All HEDIS rates in **Table 8** were administratively calculated by DHS.

Blue Plus HEDIS rates are displayed in **Table 8**. The results of the MCO's Measure Matrix analysis are presented in **Figure 4**.

Table 8: Blue Plus HEDIS Performance – Reporting Years 2018, 2019 and 2020

HEDIS Measures	Blue Plus 2018 HEDIS MY 2017	Blue Plus 2019 HEDIS MY 2018	Blue Plus 2020 HEDIS MY 2019	*QC 2020* National Medicaid Benchmark Met/Exceeded	Statewide Average MY 2019
F&C-MA					
Adolescent Well-Care Visit (12-21 Years)	37.9%	37.4%	40.4%	10th	42.6%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)	84.1%	82.6%	82.9%	75th	82.8%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)	87.7%	86.9%	86.6%	50th	86.8%
Annual Dental Visit for Children (2-18 Years)	-	55.1%	55.3%	33.33rd	57.4%
Annual Dental Visit for Adults (19-64 Years)	-	34.9%	35.1%	No Benchmark	37.4%
Breast Cancer Screening (52-74 Years)	60.7%	58.4%	58.7%	33.33rd	59.8%
Cervical Cancer Screening (24-64 Years)	58.3%	57.8%	54.4%	10th	56.3%
Childhood Immunization Status: Combo 3 (2 Years)	60.9%	55.1%	53.4%	<10th	53.0%
Children and Adolescents' Access to PCPs (12-24 Months)	96.8%	96.3%	96.2%	50th	96.3%
Children and Adolescents' Access to PCPs (25 Months-6 Years)	90.4%	88.6%	87.6%	33.33rd	88.5%
Children and Adolescents' Access to PCPs (7-11 Years)	92.5%	91.4%	91.2%	33.33rd	91.7%
Children and Adolescents' Access to PCPs (12-19 Years)	93.1%	92.3%	91.4%	50th	91.9%
Chlamydia Screening in Women (16-24 Years)	51.0%	51.3%	49.1%	10th	55.1%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)	89.3%	89.0%	78.8%	<10th	84.0%
Well-Child Visits in the First 15 Months of Life (6+ Visits)	61.4%	64.4%	64.3%	25th	64.2%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	63.7%	63.1%	64.2%	10th	65.9%

MY= measurement year; QC= NCQA 2020 Quality Compass MY 2019; PCPs= primary care providers.
All rates were calculated by DHS using the administrative methodology.
Note 1: HEDIS hybrid rates are not reported by the MCO because of NCQA reporting changes due to COVID-19. See note on pg. 19. HEDIS Hybrid measures include Adult BMI Assessment, Comprehensive Diabetes Care: Eye Exam.
Note 2: The measure 'Medication Management for People With Asthma (5-64 years)' is no longer included in this report.
Note 3: The NCQA benchmark used for the Annual Dental Visit for Children represents an expanded age group (2-20 year olds).

Table 8: Blue Plus HEDIS Performance – Reporting Years 2018, 2019 and 2020 (Continued)

HEDIS Measures	Blue Plus 2018 HEDIS MY 2017	Blue Plus 2019 HEDIS MY 2018	Blue Plus 2020 HEDIS MY 2019	*QC 2020* National Medicaid Benchmark Met/Exceeded	Statewide Average MY 2019
MNCare					
Adolescent Well-Care Visit (12-21 Years)	22.5%	21.4%	23.9%	<10th	25.4%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)	82.2%	82.0%	82.6%	75th	82.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)	88.5%	88.7%	88.9%	66.67th	88.4%
Annual Dental Visit for Children (2-18 Years)	-	49.2%	56.9%	33.33rd	54.9%
Annual Dental Visit for Adults (19-64 Years)	-	37.3%	38.3%	No Benchmark	40.0%
Breast Cancer Screening (52-64 Years)	69.8%	66.3%	65.7%	75th	64.9%
Cervical Cancer Screening (24-64 Years)	55.3%	54.6%	51.9%	10th	54.7%
Children and Adolescents' Access to PCPs (12-24 Months)	93.5%	96.4%	96.1%	50th	96.9%
Children and Adolescents' Access to PCPs (25 Months-6 Years)	90.9%	88.4%	89.6%	50th	91.2%
Children and Adolescents' Access to PCPs (12-19 Years)	90.4%	93.3%	88.4%	25th	89.4%
Chlamydia Screening in Women (16-24 Years)	49.3%	52.1%	47.9%	10th	55.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)	93.0%	93.1%	83.7%	10th	89.0%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	63.5%	61.2%	72.2%	33.33rd	71.5%

MY= measurement year; QC= NCQA 2020 Quality Compass MY 2019; PCPs= primary care providers.
All rates were calculated by DHS using the administrative methodology.
Note 1: HEDIS hybrid rates are not reported by the MCO because of NCQA reporting changes due to COVID-19. See note on pg. 19. HEDIS Hybrid measures include Adult BMI Assessment, Comprehensive Diabetes Care: Eye Exam.
Note 2: The measure 'Medication Management for People With Asthma (5-64 years)' is no longer included in this report.
Note 3: The NCQA benchmark used for the Annual Dental Visit for Children represents an expanded age group (2-20 year olds).

Table 8: Blue Plus HEDIS Performance – Reporting Years 2018, 2019 and 2020 (Continued)

HEDIS Measures	Blue Plus 2018 HEDIS MY 2017	Blue Plus 2019 HEDIS MY 2018	Blue Plus 2020 HEDIS MY 2019	*QC 2020* National Medicaid Benchmark Met/Exceeded	Statewide Average MY 2019
MSHO					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)	98.4%	98.1%	98.0%	75th	98.3%
Breast Cancer Screening (65-74 Years)	64.0%	65.3%	65.5%	75th	64.6%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)	95.1%	87.6%	87.0%	33.33rd	92.2%
MSC+					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)	90.2%	90.8%	60.2%	<10th	88.1%
Breast Cancer Screening (65-74 Years)	55.3%	56.8%	47.7%	10th	40.4%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)	86.2%	89.4%	26.6%	<10th	65.8%

MY= measurement year; QC= NCQA 2020 Quality Compass MY 2019; PCPs= primary care providers.
All rates were calculated by DHS using the administrative methodology.
Note 1: HEDIS hybrid rates are not reported by the MCO because of NCQA reporting changes due to COVID-19. See note on pg. 19.

Figure 4: Blue Plus 2020 HEDIS Measure Matrix

2018 – 2019 Rate Change	Statewide Average Statistical Significance Comparison		
	Below Average	**Statewide Average**	**Above Average**
	C ▪ Annual Dental Visit-Adults (MNCare) ▪ Adolescent Well-Care Visit (F&C-MA) ▪ Well-Child Visit in the 3rd, 4th, 5th and 6th Years of Life (F&C-MA)	**B** ▪ Annual Dental Visit-Children (MNCare) ▪ Well-Child Visit in the 3rd, 4th, 5th and 6th Years of Life (MNCare)	**A**
	D ▪ Annual Dental Visit-Adults (F&C-MA) ▪ Annual Dental Visit-Children (F&C-MA) ▪ Comprehensive Diabetes Care-HbA1c Testing (MSHO) ▪ Chlamydia Screening in Women (MNCare)	**C** ▪ Adolescent Well-Care Visit (MNCare) ▪ Breast Cancer Screening (F&C-MA, MSHO, MNCare) ▪ Childhood Immunization Status-Combo 3 (F&C-MA) ▪ Well-Child Visits in the First 15 Months of Life-6+ Visits (F&C-MA)	**B**
	F ▪ Cervical Cancer Screening (F&C-MA, MNCare) ▪ Comprehensive Diabetes Care-HbA1c Testing (F&C-MA, MSC+, MNCare) ▪ Chlamydia Screening in Women (F&C-MA)	**D**	**C** ▪ Breast Cancer Screening (MSC+)

Key to the Measure Matrix

A	Notable performance. MCO may continue with internal goals.
B	MCOs may identify continued opportunities for improvement, but no required action.
C	MCOs should identify opportunities for improvement, but no immediate action required.
D	Conduct root cause analysis and develop action plan.
F	Conduct root cause analysis and develop action plan.

Table 9: Blue Plus CAHPS Performance – 2018, 2019 and 2020

CAHPS Measures	Blue Plus CAHPS 2018	Blue Plus CAHPS 2019	Blue Plus CAHPS 2020	*QC 2020* National Medicaid Benchmark Met/Exceeded	2020 Statewide Average
F&C-MA					
Getting Needed Care*	89.4%	80.1%	80.8%	10th	81.7%
Getting Care Quickly*	83.9%	79.1%	84.4%	50th	83.8%
How Well Doctors Communicate*	96.8%	94.0%	96.7%	95th	94.7%
Customer Service*	85.5%	85.8%	81.4%	<10th	88.3%
Shared Decision Making*	84.9%	85.3%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	63.2%	46.2%	49.7%	<10th	52.5%
Rating of Personal Doctor**	73.0%	73.8%	71.9%	66.67th	71.6%
Rating of Specialist Seen Most Often**	71.3%	61.4%	56.7%	<10th	63.7%
Rating of Health Plan**	65.6%	57.7%	54.5%	10th	56.8%
MNCare					
Getting Needed Care*	88.0%	81.2%	84.1%	50th	83.3%
Getting Care Quickly*	86.4%	88.5%	85.4%	66.67th	83.2%
How Well Doctors Communicate*	93.4%	97.3%	97.5%	95th	96.9%
Customer Service*	86.1%	77.9%	85.1%	<10th	88.6%
Shared Decision Making*	82.4%	77.3%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	49.8%	52.2%	50.2%	<10th	52.2%
Rating of Personal Doctor**	66.2%	68.1%	73.2%	75th	71.5%
Rating of Specialist Seen Most Often**	69.1%	73.1%	61.0%	<10th	62.7%
Rating of Health Plan**	54.7%	54.0%	47.7%	<10th	50.9%

F&C-MA Response Rate = 21.56%. Sample Size =1,350. Complete Surveys = 284.
MNCare Response Rate = 32.00%. Sample size = 1,350. Complete Surveys = 425.
* Measure represents the percent of members who responded "yes," "usually" or "always."
** Ratings range from 0 to 10. This measure represents the percent of members who responded "9" or "10."
MY: measurement year; QC: NCQA 2020 Quality Compass MY 2019.

Table 9: Blue Plus CAHPS Performance – 2018, 2019 and 2020 (Continued)

CAHPS Measures	Blue Plus CAHPS 2018	Blue Plus CAHPS 2019	Blue Plus CAHPS 2020	*QC 2020* National Medicaid Benchmark Met/Exceeded	2020 Statewide Average
MSC+					
Getting Needed Care*	83.4%	87.2%	89.3%▲	95th	86.1%
Getting Care Quickly*	84.5%	86.1%	87.3%	90th	86.2%
How Well Doctors Communicate*	94.5%	94.3%	94.6%	75th	94.9%
Customer Service*	87.2%	87.7%	91.1%	66.67th	90.1%
Shared Decision Making*	73.7%	81.7%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	65.4%	62.8%	54.8%	25th	56.7%
Rating of Personal Doctor**	80.4%	76.3%	75.3%	75th	74.3%
Rating of Specialist Seen Most Often**	76.8%	77.1%	72.5%	66.67th	71.6%
Rating of Health Plan**	67.9%	71.1%	62.0%	33.33rd	62.4%

MSC+ Response Rate = 47.74%. Sample Size = 1,350. Complete Surveys = 592.
* Measure represents the percent of members who responded "yes," "usually" or "always."
** Ratings range from 0 to 10. This measure represents the percent of members who responded "9" or "10."
MY: measurement year; QC: NCQA 2020 Quality Compass MY 2019.
▲ Statistically significantly higher than the Total MCO program average.

BLUE PLUS FINDINGS AND RECOMMENDATIONS

Strengths

- **NCQA Accreditation Survey –** Blue Plus maintained NCQA accreditation for the F&C-MA and MNCare programs.
- **Compliance –** Blue Plus was fully compliant with the standards of *Title 42 CFR Part 438 Managed Care Subpart D* and *Title 42 CFR § 438.330*.
- **PIP –** Blue Plus designed and conducted a PIP that met the standards of *Title 42 CFR 438.330(d)* and *Section 7.2* of the DHS model contract for MCOs.
- **ISCA –** Blue Plus met all IS requirements of the HEDIS Compliance Audit and successfully reported HEDIS data.
- **Member Satisfaction (CAHPS) –** Blue Plus achieved a significantly higher score than the statewide average for the following program and measure:
    - MSC+: Getting Needed Care

Opportunities for Improvement

- **Compliance –**
    - **QAE:** Blue Plus received a total of one (1) recommendation, five (5) mandatory improvements and two (2) deficiencies for compliance with state standards.
    - **TCA:** Blue Plus received three (3) "not met" designations for compliance with state requirements.
- **Financial Withhold** – Blue Plus did not earn full points for the F&C-MA, MNCare, MSHO and MSC+ programs. The MCO did not meet the target goal for the following measures:
    - F&C-MA and MNCare
        - Annual Dental Visit for Children (aged 1-20 years)
        - Annual Dental Visit for Adults (aged 21-64 years)
        - Provider Network Equity: FFS vs. MCO
        - Emergency Department Utilization Rate
        - Hospital 30-Day Readmission Rate
    - MSHO and MSC+
        - Annual Dental Visit Rate (aged 65+ years)
- **Quality of Care (HEDIS) –** Blue Plus demonstrates an opportunity for improvement in the following areas of care:
    - F&C-MA
        - Annual Dental Visits-Adults
        - Annual Dental Visits-Children
        - Cervical Cancer Screening
        - Comprehensive Diabetes Screening: HbA1c Testing
        - Chlamydia Screening in Women
    - MNCare
        - Annual Dental Visits-Adults

- Chlamydia Screening in Women
- Cervical Cancer Screening
- Comprehensive Diabetes Screening: HbA1c Testing

o MSHO
- Comprehensive Diabetes Screening: HbA1c Testing

o MSHO
- Comprehensive Diabetes Screening: HbA1c Testing

Recommendations

- **Financial Withhold –**
  - Despite Blue Plus's efforts to increase member utilization of dental services, annual dental visit rates remain flat. Blue Plus should continue efforts to mitigate the dental provider gap. Blue Plus should consider collaborating with the other MCOs to develop a broader plan for addressing the shortage of dental providers across the state. Blue Plus should also consider working with primary care providers to provide fluoride varnish as part of routine checkups.
  - Blue Plus should continue its current strategy to address emergency department use and 30-day hospital readmissions through early identification, outreach, education and care coordination.
- **Quality of Care (HEDIS)** – Concerning women's health and diabetes care, Blue Plus should identify causes for the decline in rates related to these areas of care. Blue Plus should continue to partner with community-based organizations to promote health initiatives.

HEALTHPARTNERS

CORPORATE PROFILE

HealthPartners became a managed care entity in 1992. HealthPartners provides services to enrollees in the F&C-MA, MNCare, MSHO, MSC+ and SNBC programs. As of December 2019, enrollment totaled 154,163, accounting for 16.8% of the entire MHCP population. **Table 10** displays HealthPartners' enrollment as of December 2019.

Table 10: HealthPartners Enrollment as of December 2019

Program	Enrollment (as of December 2019)
F&C-MA	122,982
MNCare	19,456
MSC+	2,076
MSHO	3,563
SNBC	6,086
Total Enrollment	**154,163**

Source: Minnesota Health Care Enrollment Totals December 2019 Report.

QUALITY ASSURANCE EXAMINATION AND TRIENNIAL COMPLIANCE ASSESSMENT

MDH conducted the most recent QAE and TCA between March 5, 2018 and March 8, 2018. The evaluation period covered June 1, 2015 to December 31, 2017, while the file review period covered January 1, 2017 to December 31, 2017. The MCO received two (2) recommendations, two (2) mandatory improvements, and one (1) deficiency for the QAE. The MCO received one (1) "not met" designation for the TCA. The mid-cycle review (August 6, 2019 to August 7, 2019) conducted on the corrective action plan submitted by HealthPartners stated that HealthPartners had addressed the two (2) recommendations, (1) mandatory improvement and (1) deficiency. A resubmission of the HealthPartners corrective action plan for the remaining mandatory improvement was required by MDH.

The results of the TCA also concluded that HealthPartners was compliant with the standards described in 42 CFR 438 Subpart D. **Table 11** presents a summary of these findings.

Table 11: HealthPartners Compliance Review Results for Part 438 Subpart D and QAPI Standards

42 CFR 438 Subpart D and Quality Assessment and Performance Improvement Program Standards	Review Determination (Met or Not Met)
Access Standards 438.206 Availability of Services 438.207 Assurances of Adequate Capacity and Services 438.208 Coordination and Continuity of Care 438.210 Coverage and Authorization of Service	Met
Structure and Operations Standards 438.214 Provider Selection 438.224 Confidentiality and Accuracy of Enrollee Records 438.228 Grievance Systems 438.230 Sub Contractual Relationships and Delegation	Met
Measurement Improvement Standards 438.236 Practice Guidelines Program 438.242 Health Information System	Met
Written Quality Assurance Plan (Quality Program Description) 438.330 Quality Assessment and Performance Improvement Program	Met

CFR= Code of Federal Regulations

PERFORMANCE IMPROVEMENT PROJECT

DHS's validation of HealthPartners 2019 PIP confirmed its compliance with the standards of *Title 42 CFR 438.330(d)* and *Section 7.2 of* the DHS model contract for MCOs.

HealthPartners executed mail campaign designed to encourage members to forego additional opioid prescriptions in favor of alternative pain management therapies. The number of members who chose alternative therapies was monitored. Those with special needs were contacted directly by a pharmacist when a second opioid prescription was filled to ensure they understood the risks of the medications. This responsibility was eventually transferred to nurses as care coordinators. HealthPartners also collaborated with Community Paramedics to conduct home visits to assist with the safe and proper disposal of unused opioid medications. Provider interventions included the Quality Connections Forum for the sharing of lessons learned and best practices. Providers prescribing habits were monitored for the average number of pills in the first opioid prescription for a patient, the average number of days for the first prescription, and power of the prescribed medication. Direct provider outreach was conducted specifically for those who work with special needs enrollees. The primary care team treating special needs patients received letters informing them when a patient received an opioid prescription and to provide links to additional resources. Providers of all types received multitudes of fast-facts, toolkits, and monitoring report notices throughout the year. The HealthPartners opioid prescribing community awareness campaign was delivered through numerous outlets including social media, traditional media, in-hospital training videos for patients about pain and recovery, and reading materials supporting "Treating Pain Without Pills."

Table 12 presents 2017-2019 new chronic user rates for HealthPartners and the state. As this is the first reporting cycle looking back on the first year of the PIP, there is not sufficient information to draw specific conclusions.

Table 12: HealthPartners PIP Rates – New Chronic Users

Reporting Year	HealthPartners Rate	Statewide Average Rate
F&C-MA and MNCare		
2017 (baseline)	2.9%	3.5%
2018 (intervention year 1)	2.1%	2.7%
2019 (intervention year 2)	1.3%	2.1%
MSHO and MSC+		
2017 (baseline)	14.1%	18.5%
2018 (intervention year 1)	14.7%	22.9%
2019 (intervention year 2)	15.5%	14.9%
SNBC		
2017 (baseline)	8.4%	9.9%
2018 (intervention year 1)	5.8%	8.84%
2019 (intervention year 2)	4.8%	7.5%

PIP= performance improvement project.

Table 13 displays validations results for the HealthPartners PIP.

Table 13: HealthPartners PIP Validation Results

PIP Validation Elements	Validation Results
Selected Topic	Met
Study Question	Met
Indicators	Met
Population	Met
Sampling Methods	Met
Data Collection Procedures	Met
Interpretation of Study Results	Met
Improvement Strategies	Met

PIP= performance improvement project.

2019 Financial Withhold

HealthPartners achieved 3.61 points (of 100 points) for the F&C-MA and MNCare programs, achieved 81.92 points (of 90 points) for the MSHO and MSC+ programs and achieved 50.77 points (of 60 points) for the SNBC program. **Table 14** displays the results of the 2019 Financial Withhold, including performance measures, point values, and points earned by HealthPartners.

Table 14: HealthPartners 2019 Financial Withhold

Performance Measure	Point Value	Points Earned
F&C-MA and MNCare		
Annual Dental Visit: Age stratification 1-20 years	55	0
Annual Dental Visit: Age stratification 21-64 years	30	0
Provider Network Equity: FFS vs. MCO	10	0
Repeat Deficiencies on the MDH QAE	2	2
Emergency Department (ED) Utilization Rate	1	1
Hospital Admission Rate	1	0.2
Hospital 30-Day Readmission Rate	1	0.41
TOTAL	**100**	**3.61**
MSHO and MSC+		
Repeat Deficiencies on the MDH QAE	15	15
Care Plan Audit	15	15
Initial Health Risk Screening/Assessment	30	30
Stakeholder Group Reporting	15	15
Annual Dental Visit: Age 65+	15	6.92
TOTAL	**90**	**81.92**
SNBC		
Repeat Deficiencies on the MDH QAE	15	15
Compliance with Service Accessibility Requirements	15	15
Stakeholder Group Reporting	15	15
Annual Dental Visit: Age 18-64	15	5.77
TOTAL	**60**	**50.77**

FFS= fee-for-service; MCO= managed care organization;
QAE= Quality Assurance Exam.

ANNUAL QUALITY ASSURANCE WORK PLAN FOR 2019

HealthPartners developed a quality assurance work plan compliant with Minnesota Administrative Rule 4685.1130. The key priorities identified in the HealthPartners Clinical Quality Action plan for all products were to develop and execute HEDIS and CMS strategies, strengthen health and wellness initiatives, continue to promote and support optimal coordination of care, provide quality care at a lower cost, implement health improvement and network quality improvement initiatives, improve affordability of healthcare, partner with government and community relations to reduce disparities, serve a culturally and linguistically diverse membership, foster a culture of integrity, implement behavioral health strategies and interventions, enhance pharmacy management programs and ensure the safety of clinical care for members. Regarding state public programs, HealthPartners focused on improving CMS star ratings, reducing chronic opioid use amongst the senior population, supporting the CAHPS/HOS Improvement Project, implementing SNBC initiatives to ensure access to key medical and dental services, reducing the number of opioid "naïve" members and supporting Model of Care oversight. The improvement and maintenance of CMS Star Ratings was the primary focus under Medicaid. The key

priorities under PMAP were to develop and implement strategies to achieve DHS contract withholds, the use of patient activation to increase case management programs and reducing the number of opioid "naïve" members who transition to chronic opioid users. The HealthPartners monitoring plan focused on compliance readiness, program updates, evaluating the annual plan, assessment of the delegate program, annual assessment of provider complaints, annual communication to members and annual communication to providers.

Evaluation of the 2019 Annual Quality Assessment and Performance Improvement Program

The HealthPartners strategic plan focuses on triple aim values of health, experience and affordability in order to better integrate quality, population health and utilization management. HealthPartners reported health improvement outcomes in 2019 for pharmacy quality measures, behavioral health, health and wellbeing and health equity through community involvement. Affordability outcomes via a price transparency tool, leadership involvement, adequacy and realignment of resources, practitioner participation were also assessed to achieve quality improvement.

Areas of focus for 2020 include: implementing the partners for better health 2025 measures and goals, a behavioral health quality and utilization improvement strategy committee, scenario planning related to the pandemic, utilizing technology for better member engagement, introducing a new prior authorization verification tool and deploying a new member outreach campaign. Member, provider and employer interventions were employed to further improve HEDIS scores.

MCO Clinical Practice Guidelines

HealthPartners recognizes the following source for clinical practice guidelines:

- ICSI

Quality Improvement Program Website[29]

HealthPartners' quality improvement program website summarizes ways in which the MCO is improving health and providing a better patient experience. HealthPartners has aligned its mission with the Triple Aim: improving the health of the population, enhancing the patient experiences, and making health care affordable. To reward care that improves care and helps to lower the cost of care, HealthPartners incorporated two accountable care organizations (ACOs) within its network. The MCO leverages its policy platform to keep health care affordable. The website also presents quality ratings for primary care, specialty care, hospitals and same day surgery centers.

[29] HealthPartners Quality Improvement Program Website: https://www.healthpartners.com/about/improving-healthcare/

Performance Measures

Information Systems Capabilities Assessment

The 2020 HEDIS FAR for MY 2019 produced by Attest Health Care Advisors indicated that HealthPartners met all of the requirements to successfully report HEDIS data to DHS. **Table 15** displays the results of the IS audit.

Table 15: HealthPartners Compliance with Information System Standards

Information System Standard	Review Result
1.0 Medical Services Data	Met
2.0 Enrollment Data	Met
3.0 Practitioner Data	Met
4.0 Medical Record Review Processes	Met
5.0 Supplemental Data	Met
6.0 Data Preproduction Processing	Met
7.0 Data Integration and Reporting	Met

HEDIS – Quality, Timeliness and Access

Due to the coronavirus disease of 2019 (COVID-19) outbreak and in accord with NCQA recommendations, DHS and MDH allowed Medicaid MCOs to request a waiver to report audited HEDIS MY 2018 hybrid rates if they were not able to complete HEDIS MY 2019 hybrid medical record chart reviews according to NCQA technical specifications.

HealthPartners waiver to report HEDIS MY 2018 hybrid rates for HEDIS MY 2019 was approved. All HEDIS rates in **Table 16** were administratively calculated by DHS.

HealthPartners HEDIS rates are displayed in **Table 16**. The results of the MCO's Measure Matrix analysis are presented in **Figure 4**.

Table 16: HealthPartners HEDIS Performance – Reporting Years 2018, 2019 and 2020

HEDIS Measures	Health Partners 2018 HEDIS MY 2017	Health Partners 2019 HEDIS MY 2018	Health Partners 2020 HEDIS MY 2019	*QC 2020* National Medicaid Benchmark Met/Exceeded	Statewide Average MY 2019
F&C-MA					
Adolescent Well-Care Visit (12-21 Years)	39.8%	42.5%	47.2%	10th	42.6%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)	84.0%	83.7%	83.7%	75th	82.8%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)	87.8%	87.5%	87.4%	50th	86.8%
Annual Dental Visit for Children (2-18 Years)	-	56.0%	56.6%	33.33rd	57.4%
Annual Dental Visit for Adults (19-64 Years)	-	39.7%	40.3%	Not Available	37.4
Breast Cancer Screening (50-64 Years)	64.9%	64.0%	61.7%	50th	59.8%
Cervical Cancer Screening (24-64 Years)	62.8%	63.3%	61.2%	33.33rd	56.3%
Childhood Immunization Status: Combo 3 (2 Years)	67.5%	59.9%	58.1%	<10th	53.0%
Children and Adolescents' Access to PCPs (12-24 Months)	96.7%	96.9%	96.5%	50th	96.3%
Children and Adolescents' Access to PCPs (25 Months-6 Years)	91.8%	90.2%	90.0%	50th	88.5%
Children and Adolescents' Access to PCPs (7-11 Years)	92.8%	92.9%	93.4%	66.67th	91.7%
Children and Adolescents' Access to PCPs (12-19 Years)	93.5%	93.4%	93.2%	75th	91.9%
Chlamydia Screening in Women (16-24 Years)	68.1%	68.8%	68.5%	75th	55.1%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)	89.7%	86.5%	88.8%	50th	84.0%
Well-Child Visits in the First 15 Months of Life (6+ Visits)	72.4%	70.9%	70.6%	50th	64.2%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	68.0%	69.4%	70.1%	25th	65.9%

MY= measurement year; QC= NCQA 2020 Quality Compass MY 2019; PCPs= primary care providers.
All rates were calculated by DHS using the administrative methodology.
Note 1: HEDIS hybrid rates are not reported by the MCO because of NCQA reporting changes due to COVID-19. See note on pg. 19.
HEDIS Hybrid measures include Adult BMI Assessment, Comprehensive Diabetes Care: Eye Exam.
Note 2: The measure 'Medication Management for People With Asthma (5-64 years)' is no longer included in this report.
Note 3: The NCQA benchmark used for the Annual Dental Visit for Children represents an expanded age group (2-20 year olds).

Table 16: HealthPartners HEDIS Performance – Reporting Years 2018, 2019 and 2020 (Continued)

HEDIS Measures	Health Partners 2018 HEDIS MY 2017	Health Partners 2019 HEDIS MY 2018	Health Partners 2020 HEDIS MY 2019	*QC 2020* National Medicaid Benchmark Met/Exceeded	Statewide Average MY 2019
MNCare					
Adolescent Well-Care Visit (12-21 Years)	22.4%	25.1%	25.9%	<10th	25.4%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)	81.6%	81.7%	82.8%	75th	82.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)	86.8%	87.8%	88.5%	66.67th	88.4%
Annual Dental Visit for Children (2-18 Years)	-	56.4%	52.3%	25th	54.9%
Annual Dental Visit for Adults (19-64 Years)	-	39.6%	41.3%	No Benchmark	40.0%
Breast Cancer Screening (50-64 Years)	71.3%	67.6%	65.8%	75th	64.9%
Cervical Cancer Screening (24-64 Years)	57.1%	60.0%	58.9%	33.33rd	54.7%
Children and Adolescents' Access to PCPs (12-24 Months)	Small Sample	92.9%	Small Sample	Not Applicable	96.9%
Children and Adolescents' Access to PCPs (25 Months-6 Years)	90.5%	90.7%	94.6%	95th	91.2%
Children and Adolescents' Access to PCPs (12-19 Years)	90.1%	94.2%	91.1%	50th	89.4%
Chlamydia Screening in Women (16-24 Years)	60.1%	66.6%	70.3%	75th	55.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)	91.9%	91.8%	92.7%	90th	89.0%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	51.5%	74.3%	76.9%	50th	71.5%

MY= measurement year; QC= NCQA 2020 Quality Compass MY 2019; PCPs= primary care providers.
All rates were calculated by DHS using the administrative methodology.
Note 1: HEDIS hybrid rates are not reported by the MCO because of NCQA reporting changes due to COVID-19. See note on pg. 19.
HEDIS Hybrid measures include Adult BMI Assessment, Comprehensive Diabetes Care: Eye Exam.
Note 2: The measure 'Medication Management for People With Asthma (5-64 years)' is no longer included in this report.
Note 3: The NCQA benchmark used for the Annual Dental Visit for Children represents an expanded age group (2-20 year olds).

Table 16: HealthPartners HEDIS Performance – Reporting Years 2018, 2019 and 2020 (Continued)

HEDIS Measures	Health Partners 2018 HEDIS MY 2017	Health Partners 2019 HEDIS MY 2018	Health Partners 2020 HEDIS MY 2019	*QC 2020* National Medicaid Benchmark Met/Exceeded	Statewide Average MY 2019
MSHO					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)	98.1%	98.3%	98.3%	95th	98.3%
Breast Cancer Screening (65-74 Years)	61.2%	64.5%	64.2%	75th	64.6%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)	95.4%	92.5%	96.1%	95th	92.2%
MSC+					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)	91.0%	92.7%	93.2%	75th	88.1%
Breast Cancer Screening (65-74 Years)	34.4%	39.9%	48.7%	10th	40.4%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)	57.5%	69.9%	80.5%	<10th	65.8%
SNBC					
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)	94.3%	94.1%	93.7%	95th	92.7%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)	96.4%	96.3%	96.2%	95th	96.4%
Breast Cancer Screening (50-64 Years)	Small Sample	51.1%	65.1%	75th	53.3%
Cervical Cancer Screening (24-64 Years)	41.7%	46.8%	42.9%	<10th	41.3%
Chlamydia Screening in Women (16-24 Years)	48.0%	48.8%	52.4%	25th	41.1%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)	69.1%	85.3%	92.7%	90th	89.0%

MY= measurement year; QC= NCQA 2020 Quality Compass MY 2019; PCPs= primary care providers.
All rates were calculated by DHS using the administrative methodology.
Note 1: HEDIS hybrid rates are not reported by the MCO because of NCQA reporting changes due to COVID-19. See note on pg. 19.
HEDIS Hybrid measures include Adult BMI Assessment, Comprehensive Diabetes Care: Eye Exam.
Note 2: The measure 'Medication Management for People With Asthma (5-64 years)' is no longer included in this report.

Figure 5: HealthPartners 2020 HEDIS Measure Matrix

2018 – 2019 Rate Change	Statewide Average Statistical Significance Comparison		
	Below Average	**Statewide Average**	**Above Average**
	C	B	A ▪ Annual Dental Visit-Adults (MNCare) ▪ Adolescent Well-Care Visit (F&C-MA) ▪ Breast Cancer Screening (MSC+, SNBC) ▪ Comprehensive Diabetes Care-HbA1c Testing (F&C-MA, MSC+, MSHO, SNBC)
	D ▪ Annual Dental Visit-Children (F&C-MA)	C ▪ Annual Dental Visit-Children (MNCare) ▪ Adolescent Well-Care Visit (MNCare) ▪ Breast Cancer Screening (F&C-MA, MSHO, MNCare) ▪ Well-Care Visits in the 3rd, 4th, 5th and 6th Years of Life (MNCare)	B ▪ Annual Dental Visit-Adult (F&C-MA) ▪ Cervical Cancer Screening (MNCare) ▪ Comprehensive Diabetes Care-HbA1c Testing (MNCare) ▪ Chlamydia Screening in Women (F&C-MA, MNCare) ▪ Childhood Immunization Status (F&C-MA) ▪ Well-Child Visits in the First 15 Months-6+ Visits (F&C-MA) ▪ Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (F&C-MA)
	F	D ▪ Cervical Cancer Screening (SNBC)	C ▪ Cervical Cancer Screening (F&C-MA)

Key to the Measure Matrix

A Notable performance. MCO may continue with internal goals.
B MCOs may identify continued opportunities for improvement, but no required action.
C MCOs should identify opportunities for improvement, but no immediate action required.
D Conduct root cause analysis and develop action plan.
F Conduct root cause analysis and develop action plan.

Table 17: HealthPartners CAHPS Performance – 2018, 2019 and 2020

CAHPS Measures	HealthPartners CAHPS 2018	HealthPartners CAHPS 2019	HealthPartners CAHPS 2020	*QC 2020* National Medicaid Benchmark Met/Exceeded	2020 Statewide Average
F&C-MA					
Getting Needed Care*	84.4%	85.2%	84.0%	50th	81.7%
Getting Care Quickly*	83.7%	85.1%	83.9%	50th	83.8%
How Well Doctors Communicate*	97.2%	95.7%	96.9%	95th	94.7%
Customer Service*	88.3%	85.4%	90.0%	50th	88.3%
Shared Decision Making*	80.6%	85.4%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	61.8%	57.1%	57.1%	33.33rd	52.5%
Rating of Personal Doctor**	74.8%	69.7%	79.5%▲	95th	71.6%
Rating of Specialist Seen Most Often**	73.6%	68.5%	73.1%	66.67th	63.7%
Rating of Health Plan**	62.0%	61.2%	60.6%	33.33rd	56.8%
MNCare					
Getting Needed Care*	85.7%	86.4%	83.0%	33.33rd	83.3%
Getting Care Quickly*	83.1%	86.1%	77.6%▼	10th	83.2%
How Well Doctors Communicate*	96.0%	92.9%	96.2%	90th	96.9%
Customer Service*	93.0%	90.0%	93.8%▲	95th	88.6%
Shared Decision Making*	83.2%	80.9%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	53.7%	55.0%	58.2%	<10th	52.2%
Rating of Personal Doctor**	70.7%	69.1%	70.4%	50th	71.5%
Rating of Specialist Seen Most Often**	68.3%	67.9%	67.3%	25th	62.7%
Rating of Health Plan**	57.1%	58.5%	53.4%	<10th	50.9%

F&C-MA Response Rate = 22.38%. Sample Size = 1,350. Complete Surveys = 297.
MNCare Response Rate = 30.76%. Sample Size = 1,350. Complete Surveys = 402.
* Measure represents the percent of members who responded "yes," "usually" or "always."
** Ratings range from 0 to 10. This measure represents the percent of members who responded "9" or "10."
▲ Statistically significantly higher than the Total MCO program average.
▼ Statistically significantly lower than the Total MCO program average.

Table 17: HealthPartners CAHPS Performance – 2018, 2019 and 2020 (Continued)

CAHPS Measures	HealthPartners CAHPS 2018	HealthPartners CAHPS 2019	HealthPartners CAHPS 2020	*QC 2020* National Medicaid Benchmark Met/Exceeded	2020 Statewide Average
MSC+					
Getting Needed Care*	82.4%	82.3%	85.3%	50th	86.1%
Getting Care Quickly*	77.8%	83.3%	84.9%	66.67th	86.2%
How Well Doctors Communicate*	93.1%	94.1%	97.4%▲	95th	94.9%
Customer Service*	86.4%	88.5%	90.5%	50th	90.1%
Shared Decision Making*	75.2%	82.0%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	59.3%	55.6%	57.0%	33.33rd	56.7%
Rating of Personal Doctor**	75.1%	69.3%	74.9%	75th	74.3%
Rating of Specialist Seen Most Often**	65.6%	66.4%	70.8%	50th	71.6%
Rating of Health Plan**	67.9%	61.1%	60.2%	33.33rd	62.4%
SNBC					
Getting Needed Care*	84.6%	80.6%	82.2%	33.33rd	83.6%
Getting Care Quickly*	89.1%	81.6%	84.7%	50th	84.7%
How Well Doctors Communicate*	94.2%	94.7%	93.3%	33.33rd	93.9%
Customer Service*	91.1%	93.9%	90.5%	50th	89.5%
Shared Decision Making*	79.7%	79.1%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	52.7%	56.1%	48.2%▼	<10th	53.0%
Rating of Personal Doctor**	69.3%	71.3%	68.6%▼	33.33rd	72.3%
Rating of Specialist Seen Most Often**	63.2%	68.0%	64.5%	10th	66.9%
Rating of Health Plan**	64.0%	59.8%	55.3%	10th	58.3%

MSC+ Response Rate = 38.09%. Sample Size = 1,350. Complete Surveys = 470.
SNBC Response Rate = 37.70%. Sample Size = 1,350. Complete Surveys = 492.
* Measure represents the percent of members who responded "yes," "usually" or "always."
** Ratings range from 0 to 10. This measure represents the percent of members who responded "9" or "10."
▲ Statistically significantly higher than the Total MCO program average.
▼ Statistically significantly lower than the Total MCO program average.

HEALTHPARTNERS FINDINGS AND RECOMMENDATIONS

Strengths

- **Compliance –** HealthPartners was fully compliant with the standards of *Title 42 CFR Part 438 Managed Care Subpart D* and *Title 42 CFR § 438.330*.
- **PIP –** HealthPartners designed and conducted a PIP that met the standards of *Title 42 CFR 438.330(d)* and *Section 7.2* of the DHS model contract for MCOs.
- **ISCA –** HealthPartners met all IS requirements of the HEDIS Compliance Audit and successfully reported HEDIS data.
- **Quality of Care (HEDIS)** – HealthPartners demonstrates an opportunity for improvement in the following area of care:
    - F&C-MA
        - Adolescent Well-Care Visit
        - Comprehensive Diabetes Care-HbA1c Testing
    - MNCare
        - Annual Dental Visit-Adult
    - MSHO
        - Comprehensive Diabetes Care-HbA1c Testing
    - MSC+
        - Breast Cancer Screening
        - Comprehensive Diabetes Care-HbA1c Testing
    - SNBC
        - Comprehensive Diabetes Care-HbA1c Testing

- **Member Satisfaction (CAHPS) –** HealthPartners achieved a significantly higher score than the statewide average for the following programs and measures:
    - F&C-MA: Rating of Personal Doctor
    - MNCare: Customer Service
    - MSC+: How Well Doctors Communicate

Opportunities for Improvement

- **Compliance –**
    - **QAE:** HealthPartners received two (2) recommendations, two (2) mandatory improvements and one (1) deficiency for compliance with state standards.
    - **TCA:** HealthPartners received one (1) "not met" designation for compliance with state requirements.
- **Financial Withhold** – HealthPartners did not earn full points for the F&C-MA, MNCare, MSHO, MSC+ and SNBC programs. The MCO did not meet the target goal for the following measures:
    - F&C-MA and MNCare
        - Annual Dental Visit for Children (aged 1-20 years)

- Annual Dental Visit for Adults (aged 21-64 years)
- Provider Network Equity: FFS vs. MCO
- Hospital Admission Rate
- Hospital 30-Day Readmission Rate

o MSHO and MSC+
  - Annual Dental Visit Rate (aged 65+ years)

o SNBC
  - Annual Dental Visit Rate (aged 18-64 years)

- **Member Satisfaction (CAHPS) –** HealthPartners achieved a significantly lower score than the statewide average for the following programs and measures:
  - o MNCare: Getting Care Quickly
  - o SNBC: 'Rating of All Health Care' and 'Rating of Personal Doctor
- **Quality of Care (HEDIS) –** HealthPartners demonstrates an opportunity for improvement in the following areas of care:
  - o F&C-MA
    - Annual Dental Visit-Children
  - o SNBC
    - Cervical Cancer Screening

Recommendations

- **Financial Withhold** –
  - 0 Despite having several interventions and initiatives in place, HealthPartners' hospital admission and 30-day hospital readmission rates remain consistent. HealthPartners should assess the effectiveness of each initiative with well-defined tracking measures and expand upon those determined to be highly effective.
  - 0 As dental rates have trended upward, HealthPartners should continue the established initiatives described in its response to the previous year's recommendation. HealthPartners should consider collaborating with the other MCOs to develop a broader plan for addressing the shortage of dental providers across the state.
- **Member Satisfaction (CAHPS) –** As HSAG identified, SNBC members not receiving care as quickly as they needed it as a key driver for the SNBC 'Rating of All Health Care' score, HealthPartners should focus on improving access to care and appointment availability. HealthPartners should identify the causes for the recent decline in member satisfaction with Getting Care Quickly in the MNCare program and Rating of Personal Doctor in the SNBC program.

HENNEPIN HEALTH

CORPORATE PROFILE

Hennepin Health was a Medicaid Expansion demonstration project contracted with DHS for single adults without children ages 19-64 in Hennepin County, which ran from January 1, 2012 through December 31, 2015. Metropolitan Health Plan (MHP) managed the Hennepin Health program under its HMO license. MHP has been a licensed HMO since 1983 and has provided medical assistance benefits to public program enrollees since 1984. The Hennepin Health service model combines a social service approach with behavioral health and medical services. Effective January 1, 2016, DHS awarded MHP/Hennepin Health an F&C-MA/MNCare contract; thus, changing from a Medicaid Expansion demonstration project to offering benefits to the F&C-MA and MNCare populations. Hennepin Health's F&C-MA and MNCare programs continue to combine a social service approach with behavioral health and medical services. When MHP changed its name to Hennepin Health in September 2016, the F&C-MA/MNCare program was renamed Hennepin Health – PMAP/MNCare. Cornerstone, Hennepin Health's SNBC program, was renamed Hennepin Health – SNBC. As of December 2019, enrollment totaled 24,173, accounting for 2.6% of the entire MHCP population. **Table 1** displays Hennepin Health's enrollment as of December 2019.

Table 18: Hennepin Health Enrollment as of December 2019

Program	Enrollment (as of December 2019)
F&C-MA	20,646
MNCare	1,558
SNBC	1,969
Total Enrollment	**24,173**

Source: Minnesota Health Care Enrollment Totals December 2019 Report

QUALITY ASSURANCE EXAMINATION AND TRIENNIAL COMPLIANCE ASSESSMENT

MDH conducted the most recent QAE and TCA on September 9 through September 13, 2019. The examination period covered January 1, 2017 to June 30, 2019, while the file review period covered July 1, 2018 to June 30, 2019. The MCO received a total of three (3) mandatory improvements, and three (3) deficiencies for the QAE. The MCO received two (2) "not met" designations for the TCA. However, the results of the TCA also concluded that Hennepin Health was compliant with the standards described in 42 CFR 438 Subpart D. **Table 19** presents a summary of these findings.

Table 19: Hennepin Health Compliance Review Results for Part 438 Subpart D and QAPI Standards

42 CFR 438 Subpart D and Quality Assessment and Performance Improvement Program Standards	Review Determination (Met or Not Met)
Access Standards 438.206 Availability of Services 438.207 Assurances of Adequate Capacity and Services 438.208 Coordination and Continuity of Care 438.210 Coverage and Authorization of Service	Met
Structure and Operations Standards 438.214 Provider Selection 438.224 Confidentiality and Accuracy of Enrollee Records 438.228 Grievance Systems 438.230 Sub Contractual Relationships and Delegation	Met
Measurement Improvement Standards 438.236 Practice Guidelines Program 438.242 Health Information System	Met
Written Quality Assurance Plan (Quality Program Description) 438.330 Quality Assessment and Performance Improvement Program	Met

CFR= Code of Federal regulations

PERFORMANCE IMPROVEMENT PROJECT

DHS's validation of Hennepin Health's 2019 PIP confirmed its compliance with the standards of *Title 42 CFR 438.330(d)* and *Section 7.2 of* the DHS model contract for MCOs.

Hennepin Health leveraged the successes of the Collaborative and focused on broad outreach to critical stakeholders. Messaging and resources were made available at wellness events. The coordination of efforts was strengthened between the Hennepin Health PIP coordinator and the Hennepin County Opioid Coordinator to enhance outreach and impacts. Community stakeholders were engaged in the messaging and training of the coordinated approaches from areas such as the Hennepin County Sheriff's Office, Hennepin County Environmental Services and the Hennepin Regional Poison Center. Hennepin Health's Associate Medical Director published an article focused on prescribing risks of opioids in the Navitus Pharmacy Newsletter.

Table 20 presents 2017-2019 new chronic user rates for Hennepin Health and the state. As this is the first reporting cycle looking back on the first year of the PIP, there is not sufficient information to draw specific conclusions.

Table 20: Hennepin Health PIP Rates – New Chronic Users

Reporting Year	Hennepin Health Rate	Statewide Average Rate
F&C-MA and MNCare		
2017 (baseline)	3.9%	3.5%
2018 (intervention year 1)	3.6%	2.7%
2019 (intervention year 2)	2.3%	2.1%
SNBC		
2017 (baseline)	6.0%	9.9%
2018 (intervention year 1)	5.9%	8.84%
2019 (intervention year 2)	7.0%	7.5%

PIP= performance improvement project.

Table 21 displays validations results for the Hennepin Health PIP.

Table 21: Hennepin Health PIP Validation Results

PIP Validation Elements	Validation Results
Selected Topic	Met
Study Question	Met
Indicators	Met
Population	Met
Sampling Methods	Met
Data Collection Procedures	Met
Interpretation of Study Results	Met
Improvement Strategies	Met

PIP= performance improvement project.

2019 Financial Withhold

Hennepin Health achieved 43.50 points (of 100 points) for the F&C-MA and MNCare programs, and achieved 47.35 points (of 60 points) for the SNBC program. **Table 22** displays the results of the 2019 Financial Withhold, including performance measures, point values, and points earned by Hennepin Health.

Table 22: Hennepin Health 2019 Financial Withhold

Performance Measure	Point Value	Points Earned
F&C-MA and MNCare	-	-
Annual Dental Visit: Age stratification 1-20 years	55	38.5
Annual Dental Visit: Age stratification 21-64 years	30	0
Provider Network Equity: FFS vs. MCO	10	0
Repeat Deficiencies on the MDH QAE	2	2
Emergency Department (ED) Utilization Rate	1	1
Hospital Admission Rate	1	1
Hospital 30-Day Readmission Rate	1	1
TOTAL	**100**	**43.50**
SNBC	-	-
Repeat Deficiencies on the MDH QAE	15	15
Compliance with Service Accessibility Requirements	15	15
Stakeholder Group Reporting	15	15
Annual Dental Visit: Age 18-64	15	2.35
TOTAL	**60**	**47.35**

FFS= fee-for-service; MCO= managed care organization;
QAE= Quality Assurance Exam.

Annual Quality Assurance Work Plan for 2019

Hennepin Health's quality assurance work plan was compliant with Minnesota Administrative Rule 4685.1130. The work plan is designed around the Institute for Healthcare Improvement's Triple Aim, the Institute of Medicine's Quality Definition, and the National Association of Healthcare Quality, referred to as "quality connections," as well as the MCO's five strategic goals. Each activity included in the work plan is directly linked to at least one of the aspects of the quality connections, as well as at least one strategic goal. Detailed descriptions of the goals and objectives, outcome measures, actions to be taken, timelines, responsible staff, and project status are provided for each activity. Activities are organized into overarching categories, such as compliance, appeals and grievances, case and disease management, and member and provider satisfaction, among others.

Evaluation of the 2019 Annual Quality Assessment and Performance Improvement Program

Hennepin Health supports eligibility renewal projects, which address the issue of member eligibility lapse. In 2019 Hennepin Health implemented interventions using member, provider and system-level QI initiatives combining CAHPS data with other data sources for a comprehensive view of member satisfaction. Some of the new initiatives implemented by Hennepin Health in 2019 were a PHM strategy based on the NCQA "Standards and Guidelines for Accreditation of Health Plans," a SNBC care coordination program to assist members in accessing their health care benefits and a utilization management program leading to a transition to a new care management software called Essette.

Hennepin Health met the goals they set for network adequacy, accessibility of practitioners, availability of services, contracting, provider satisfaction survey results, provider communication, provider operations, process and documentation and network management coordination under Access to Care.

MCO Clinical Practice Guidelines

Hennepin Health recognizes the following source for clinical practice guidelines:

- ADA
  - Diabetes Type 2: Diagnosis and Management
- CDC
  - Pain Management: Non-Opioid Treatment Options and Opioid Management
- Minnesota Community Measurement (MNCM) D5
  - Diabetes Type 2: Diagnosis and Management
- American College of Obstetricians and Gynecologists[30] (ACOG)
  - Prenatal and Postpartum Care
- USPSTF
  - Prenatal and Postpartum Care
  - Preventive Services for Adults
  - Preventive Services for Children/Adolescents
  - Treatment of Patients with Major Depressive Disorder, Adults
- Agency for Healthcare Research and Quality[31] (AHRQ)
  - Preventive Services for Adults
- American Academy of Pediatrics[32] (AAP)
  - Preventive Services for Children and Adolescents
  - Attention Deficit Hyperactivity Disorder in Children
- Minnesota Department of Health
  - Preventive Services for Children/Adolescents
- APA
  - Treatment of Patients with Alcohol Use Disorder
  - Treatment of Schizophrenia
- ICSI
  - Diabetes Type 2: Diagnosis and Management
  - Pain Management: Non-Opioid Treatment Options and Opioid Management
  - Treatment of Patients with Major Depressive Disorder, Adults
  - ADHD Endorsement Summary
- American Society of Addiction Medicine[33] (ASAM)

[30] The American College of Obstetricians and Gynecologists Website: https://www.acog.org/
[31] Agency for Healthcare Research and Quality Website: https://www.ahrq.gov/
[32] American Academy of Pediatrics Website: https://www.aap.org/en-us/Pages/Default.aspx

- Treatment of Patients with Addiction to Opioids
- American Academy of Family Physicians[34] (AAFP)
  - Preventive Services for Adult – Summary of Recommendations for Clinical Preventive Services

Quality Improvement Program Website[35]

Hennepin Health's quality improvement program website is organized by mission, philosophy, goals and quality improvement initiatives for 2019. The goals of Hennepin Health's quality management program include: improving members' health; making continuous and sustained improvement in performance improvement indicators as measured by standardized industry measurement methods; ensuring that the health care delivered meets community quality, accessibility and appropriateness of setting standards; ensuring members have access to appropriate care that is needed; achieving and maintaining member satisfaction; and addressing racial disparities in appropriate quality improvement activities. Quality improvement initiatives for 2019 included: CAHPS survey; HEDIS summary; homelessness readmission pilot; increasing medication adherence; increasing member satisfaction through website improvement; reducing chronic opioid use; SNBC dental access improvement and evaluation.

Performance Measures

Information Systems Capabilities Assessment

The 2020 HEDIS FAR for MY 2019 produced by MetaStar indicated that Hennepin Health met all of the requirements to successfully report HEDIS data to DHS. **Table 23** displays the results of the IS audit.

Table 23: Hennepin Health Compliance with Information System Standards

Information System Standard	Review Result
1.0 Medical Services Data	Met
2.0 Enrollment Data	Met
3.0 Practitioner Data	Met
4.0 Medical Record Review Processes	Met
5.0 Supplemental Data	Met
6.0 Data Preproduction Processing	Met
7.0 Data Integration and Reporting	Met

[33] American Society of Addiction Medicine Website: https://www.asam.org/
[34] American Academy of Family Physicians Website: https://www.aafp.org/home.html
[35] Hennepin Health Quality Improvement Program Website: https://www.hennepinhealth.org/quality

HEDIS – Quality, Timeliness and Access

Due to the coronavirus disease of 2019 (COVID-19) outbreak and in accord with NCQA recommendations, DHS and MDH allowed Medicaid MCOs to request a waiver to report audited HEDIS MY 2018 hybrid rates if they were not able to complete HEDIS MY 2019 hybrid medical record chart reviews according to NCQA technical specifications.

Hennepin Health's waiver to report HEDIS MY 2018 hybrid rates for HEDIS MY 2019 was approved. All HEDIS rates in **Table 24** were administratively calculated by DHS.

Hennepin Health HEDIS rates are displayed in **Table 24**. The results of the MCO's Measure Matrix analysis are presented in **Figure 6**.

Table 24: Hennepin Health HEDIS Performance – Reporting Years 2018, 2019 and 2020

HEDIS Measures	Hennepin Health 2018 HEDIS MY 2017	Hennepin Health 2019 HEDIS MY 2018	Hennepin Health 2020 HEDIS MY 2019	*QC 2020* National Medicaid Benchmark Met/Exceeded	Statewide Average MY 2019
F&C-MA					
Adolescent Well-Care Visit (12-21 Years)	37.0%	41.3%	43.9%	10th	42.6%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)	67.0%	66.3%	68.1%	10th	82.8%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)	80.8%	78.7%	78.6%	10th	86.8%
Annual Dental Visit for Children (2-18 Years)	-	55.9%	57.7%	33.33rd	57.4%
Annual Dental Visit for Adults (19-64 Years)	-	28.3%	27.6%	Not Available	37.4%
Breast Cancer Screening (50-64 Years)	52.9%	53.2%	47.9%	10th	59.8%
Cervical Cancer Screening (24-64 Years)	44.3%	50.3%	48.0%	10th	56.3%
Childhood Immunization Status: Combo 3 (2 Years)	Small Sample	49.1%	43.2%	<10th	53.0%
Children and Adolescents' Access to PCPs (12-24 Months)	85.1%	90.2%	93.4%	10th	96.3%
Children and Adolescents' Access to PCPs (25 Months-6 Years)	83.8%	80.5%	80.6%	<10th	88.5%
Children and Adolescents' Access to PCPs (7-11 Years)	Small Sample	72.2%	86.3%	10th	91.7%
Children and Adolescents' Access to PCPs (12-19 Years)	Small Sample	73.0%	86.5%	10th	91.9%
Chlamydia Screening in Women (16-24 Years)	70.4%	69.9%	72.1%	90th	55.1%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)	83.1%	84.7%	85.1%	10th	84.0%
Well-Child Visits in the First 15 Months of Life (6+ Visits)	34.4%	43.0%	57.0%	10th	64.2%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	56.0%	61.4%	63.9%	10th	65.9%

MY= measurement year; QC= NCQA 2020 Quality Compass MY 2019; PCPs= primary care providers.
All rates were calculated by DHS using the administrative methodology.
Note 1: HEDIS hybrid rates are not reported by the MCO because of NCQA reporting changes due to COVID-19. See note on pg. 19. HEDIS Hybrid measures include Adult BMI Assessment, Comprehensive Diabetes Care: Eye Exam.
Note 2: The measure 'Medication Management for People With Asthma (5-64 years)' is no longer included in this report.
Note 3: The NCQA benchmark used for the Annual Dental Visit for Children represents an expanded age group (2-20 year olds).

Table 24: Hennepin Health HEDIS Performance – Reporting Years 2018, 2019 and 2020 (Continued)

HEDIS Measures	Hennepin Health 2018 HEDIS MY 2017	Hennepin Health 2019 HEDIS MY 2018	Hennepin Health 2020 HEDIS MY 2019	*QC 2020* National Medicaid Benchmark Met/Exceeded	Statewide Average MY 2019
MNCare					
Adolescent Well-Care Visit (12-21 Years)	Small Sample	22.6%	26.5%	<10th	25.4%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)	78.9%	75.8%	79.4%	50th	82.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)	94.3%	84.2%	85.5%	33.33rd	88.4%
Annual Dental Visit for Children (2-18 Years)	-	Small Sample	Small Sample	Not Applicable	54.9%
Annual Dental Visit for Adults (19-64 Years)	-	34.2%	31.2%	No Benchmark	40.0%
Breast Cancer Screening (50-64 Years)	Small Sample	Small Sample	58.2%	33.33rd	64.9%
Cervical Cancer Screening (24-64 Years)	44.9%	54.7%	52.1%	10th	54.7%
Chlamydia Screening in Women (16-24 Years)	Small Sample	Small Sample	Small Sample	Not Applicable	55.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)	Small Sample	91.4%	94.8%	95th	89.0%
SNBC					
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	88.6%	89.2%	90.6%	95th	92.7%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	94.2%	93.7%	93.4%	95th	96.4%
Breast Cancer Screening (50-64 Years)[2]	42.6%	Small Sample	54.2%	25th	53.3%
Cervical Cancer Screening (24-64 Years)[2]	46.5%	49.7%	45.2%	<10th	41.3%
Chlamydia Screening in Women (16-24 Years)[2]	Small Sample	Small Sample	Small Sample	Not Applicable	41.1%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1]	50.0%	83.9%	86.2%	25th	80.6%

MY= measurement year; QC= NCQA 2020 Quality Compass MY 2019; PCPs= primary care providers.
All rates were calculated by DHS using the administrative methodology.
Note 1: HEDIS hybrid rates are not reported by the MCO because of NCQA reporting changes due to COVID-19. See note on pg. 19. HEDIS Hybrid measures include Adult BMI Assessment, Comprehensive Diabetes Care: Eye Exam.
Note 2: The measure 'Medication Management for People With Asthma (5-64 years)' is no longer included in this report.
Note 3: The NCQA benchmark used for the Annual Dental Visit for Children represents an expanded age group (2-20 year olds).

Figure 6: Hennepin Health 2020 HEDIS Measure Matrix

2018 – 2019 Rate Change	Statewide Average Statistical Significance Comparison		
	Below Average	**Statewide Average**	**Above Average**
		B ▪ Well-Child Visits in the First 15 Months of Life-6+ visits (F&C-MA)	**A**
	D ▪ Annual Dental Visit-Adult (F&C-MA) ▪ Breast Cancer Screening (F&C-MA) ▪ Cervical Cancer Screening (F&C-MA) ▪ Childhood Immunization Status-Combo 3 (F&C-MA)	**C** ▪ Annual Dental Visit-Children (F&C-MA) ▪ Adolescent Well-Care Visit (F&C-MA, MNCare) ▪ Cervical Cancer Screening (MNCare) ▪ Comprehensive Diabetes Care-HbA1c Testing (F&C-MA) ▪ Well-Care Visits in the 3rd, 4th, 5th and 6th Years of Life (F&C-MA)	**B** ▪ Cervical Cancer Screening (SNBC) ▪ Comprehensive Diabetes Care-HbA1c Testing (MNCare, SNBC) ▪ Chlamydia Screening in Women (F&C-MA)
	F	**D**	**C**

Key to the Measure Matrix

A	Notable performance. MCO may continue with internal goals.
B	MCOs may identify continued opportunities for improvement, but no required action.
C	MCOs should identify opportunities for improvement, but no immediate action required.
D	Conduct root cause analysis and develop action plan.
F	Conduct root cause analysis and develop action plan.

Table 25: Hennepin Health CAHPS Performance – 2018, 2019 and 2020

CAHPS Measures	Hennepin Health CAHPS 2018	Hennepin Health CAHPS 2019	Hennepin Health CAHPS 2020	*QC 2020* National Medicaid Benchmark Met/Exceeded	2020 Statewide Average
F&C-MA					
Getting Needed Care*	79.6%	81.5%	87.0%	75th	81.7%
Getting Care Quickly*	74.25	85.6%	81.2%	33.33rd	83.8%
How Well Doctors Communicate*	93.4%	94.5%	90.1%	<10th	94.7%
Customer Service*	83.6%	83.0%	88.3%	25th	88.3%
Shared Decision Making*	77.1%	88.2%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	39.7%	51.3%	51.2%	<10th	52.5%
Rating of Personal Doctor**	66.4%	71.8%	68.4%	33.33rd	71.6%
Rating of Specialist Seen Most Often**	62.1%	61.5%	59.7%	<10th	63.7%
Rating of Health Plan**	44.0%	44.0%	49.8%	<10th	56.8%
MNCare					
Getting Needed Care*	86.1%	86.3%	84.6%	50th	83.3%
Getting Care Quickly*	87.7%	86.2%	88.5%▲	95th	83.2%
How Well Doctors Communicate*	96.1%	95.8%	97.0%	95th	96.9%
Customer Service*	89.8%	82.7%	86.8%	10th	88.6%
Shared Decision Making*	83.9%	76.7%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	51.9%	50.5%	49.0%	<10th	52.2%
Rating of Personal Doctor**	69.2%	71.1%	70.1%	50th	71.5%
Rating of Specialist Seen Most Often**	65.6%	65.5%	58.7%	<10th	62.7%
Rating of Health Plan**	53.8%	56.1%	47.8%	<10th	50.9%

F&C-MA Response Rate = 16.07%. Sample Size = 1,350. Complete Surveys = 214.
MNCare Response Rate= 35.30%. Sample Size = 1,350. Complete Surveys = 467.
* Measure represents the percent of members who responded "yes," "usually" or "always."
** Ratings range from 0 to 10. This measure represents the percent of members who responded "9" or "10."
QC: NCQA 2020 Quality Compass MY 2019; MY: measurement year.
▲ Statistically significantly higher than the Total MCO program average.

Table 25: Hennepin Health CAHPS Performance – 2018, 2019 and 2020 (Continued)

CAHPS Measures	Hennepin Health CAHPS 2018	Hennepin Health CAHPS 2019	Hennepin Health CAHPS 2020	*QC 2020* National Medicaid Benchmark Met/Exceeded	2020 Statewide Average
SNBC					
Getting Needed Care*	80.3%	81.3%	83.8%	50th	83.6%
Getting Care Quickly*	81.4%	82.4%	85.4%	66.67th	84.7%
How Well Doctors Communicate*	95.1%	93.7%	94.6%	75th	93.9%
Customer Service*	89.0%	85.1%	91.7%	75th	89.5%
Shared Decision Making*	78.7%	81.8%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	53.1%	56.8%	55.4%	33.33rd	53.0%
Rating of Personal Doctor**	72.0%	70.6%	72.9%	75th	72.3%
Rating of Specialist Seen Most Often**	61.4%	61.8%	72.9%	66.67th	66.9%
Rating of Health Plan**	57.4%	59.5%	61.0%	33.33rd	58.3%

SNBC Response Rate = 27.06%. Sample Size = 1,350. Complete Surveys = 27.06%.
* Measure represents the percent of members who responded "yes," "usually" or "always."
** Ratings range from 0 to 10. This measure represents the percent of members who responded "9" or "10."
QC: NCQA 2020 Quality Compass MY 2019; MY: measurement year.

HENNEPIN HEALTH FINDINGS AND RECOMMENDATIONS

Strengths

- **Compliance –** Hennepin Health was fully compliant with the standards of *Title 42 CFR Part 438 Managed Care Subpart D* and *Title 42 CFR § 438.330*.
- **PIP –** Hennepin Health designed and conducted a PIP that met the standards of *Title 42 CFR 438.330(d)* and *Section 7.2* of the DHS model contract for MCOs.
- **ISCA –** Hennepin Health met all IS requirements of the HEDIS Compliance Audit and successfully reported HEDIS data.
- **Member Satisfaction (CAHPS) –** Hennepin Health achieved a significantly higher score than the statewide average for the following programs and measures:
    - MNCare: Getting Care Quickly

Opportunities for Improvement

- **Compliance –**
    - **QAE:** Hennepin Health received three (3) mandatory improvements and three (3) deficiencies for compliance with state standards.
    - **TCA:** Hennepin Health received two (2) "not met" designations for compliance with state requirements.
- **Financial Withhold** – Hennepin Health did not earn full points for the F&C-MA, MNCare, MSHO, MSC+ and SNBC programs. The MCO did not meet the target goal for the following measures:
    - F&C-MA and MNCare
        - Annual Dental Visit for Children (aged 1-20 years)
        - Annual Dental Visit for Adults (aged 21-64 years)
        - Provider Network Equity: FFS vs. MCO
    - SNBC
        - Annual Dental Visit Rate (aged 18-64 years)
- **Quality of Care (HEDIS)** – Hennepin Health demonstrates an opportunity for improvement in regard to the following areas of care:
    - F&C-MA
        - Annual Dental Visit-Adults
        - Breast Cancer Screening
        - Cervical Cancer Screening
        - Childhood Immunization Status-Combo 3

Recommendations

- **Compliance –** To achieve full compliance with state standards, Hennepin Health should implement a corrective action plan to addresses the findings of the most recent QAE and TCA.

- **Financial Withhold –** Hennepin Health should continue the initiatives described in its response to the previous year's recommendation to improve dental care and access to dental care. Hennepin Health should consider collaborating with the other MCOs to develop a broader plan for addressing the shortage of dental providers across the state.
- **Quality of Care (HEDIS)** –
    - Hennepin Health should continue to work towards expanding access to dental care. In addition to educating members on the importance of oral care, Hennepin Health should remind members that dental care is included in the benefit package.
    - Concerning breast cancer screenings, cervical cancer screenings and childhood immunizations, rates for related performance measures have declined despite the elaborate quality improvement strategy Hennepin Health has in place. IPRO recommends that Hennepin Health determine if there are any common drivers across these measures and the populations associated with these measures.

ITASCA MEDICAL CARE (IMCARE)

CORPORATE PROFILE

Itasca County Health and Human Services (ICHHS) administers IMCare, a County-Based Purchasing (CBP) organization. Itasca County contracts with DHS to provide medical benefits through the IMCare program to the F&C-MA, MNCare, MSHO, and MSC+ populations. As of December 2019, enrollment totaled 8,006 accounting for 0.9% of the entire MHCP population. **Table 26** displays IMCare's enrollment as of December 2019.

Table 26: IMCare Enrollment as of December 2019

Program	Enrollment (as of December 2019)
F&C-MA	6,690
MNCare	646
MSC+	240
MSHO	430
Total Enrollment	**8,006**

Source: Minnesota Health Care Enrollment Totals December 2019 Report

QUALITY ASSURANCE EXAMINATION AND TRIENNIAL COMPLIANCE ASSESSMENT

In 2018, MDH conducted the most recent QAE and TCA examination on August 13, 2018 through August 17, 2018. The examination period covered November 1, 2015 to August 1, 2018, while the file review period covered June 1, 2017 to May 31, 2018. The MCO received a total of three (3) mandatory improvements and two (2) deficiencies for the QAE. The MCO received three (3) "not met" designations for the TCA. However, the results of the TCA also concluded that IMCare was compliant with the standards described in 42 CFR 438 Subpart D. **Table 27** presents a summary of these findings.

Table 27: IMCare Compliance Review Results for Part 438 Subpart D and QAPI Standards

42 CFR 438 Subpart D and Quality Assessment and Performance Improvement Program Standards	Review Determination (Met or Not Met)
Access Standards 438.206 Availability of Services 438.207 Assurances of Adequate Capacity and Services 438.208 Coordination and Continuity of Care 438.210 Coverage and Authorization of Service	Met
Structure and Operations Standards 438.214 Provider Selection 438.224 Confidentiality and Accuracy of Enrollee Records 438.228 Grievance Systems 438.230 Sub Contractual Relationships and Delegation	Met
Measurement Improvement Standards 438.236 Practice Guidelines Program 438.242 Health Information System	Met
Written Quality Assurance Plan (Quality Program Description) 438.330 Quality Assessment and Performance Improvement Program	Met

CFR= Code of Federal Regulations

PERFORMANCE IMPROVEMENT PROJECT

DHS's validation of IMCare's 2019 PIP confirmed its compliance with the standards of *Title 42 CFR 438.330(d)* and *Section 7.2 of* the DHS model contract for MCOs.

IMCare began addressing opioid related problems in Itasca County prior to the implementation of this PIP. These interventions spanned providers, sheriff's department authorities and network pharmacies, and were integrated to IMCare's PIP infrastructure at the beginning of this project. The results of IMCare's Controlled Substance Focused study assisted IMCare in identifying the need for enrollee education, the need for case management, the importance of Restricted Recipient Program placement, and identification of fraud and abuse. Unsafe prescribing patterns were forwarded to the IMCare medical director, who intervened when appropriate. Additionally, IMCare instituted numerous formulary changes based on the DHS Universal Pharmacy Policy Workgroup recommendations. Point-of-sale restrictions on opioids and prior authorizations based on limits compatible with prescribing guidelines were instituted at partner pharmacies.

Table 28 presents 2017-2019 new chronic user rates for IMCare and the state. As this is the first reporting cycle looking back on the first year of the PIP, there is not sufficient information to draw specific conclusions.

Table 28: IMCare PIP Rates – New Chronic Users

Reporting Year	IMCare Rate	Statewide Average Rate
F&C-MA and MNCare		
2017 (baseline)	3.4%	3.5%
2018 (intervention year 1)	2.7%	2.7%
2019 (intervention year 2)	2.7%	2.1%
MSHO and MSC+		
2017 (baseline)	14.8%	18.5%
2018 (intervention year 1)	16.1%	22.9%
2019 (intervention year 2)	26.2%	14.9%

PIP= performance improvement project.

Table 29 displays validations results for the IMCare PIP.

Table 29: IMCare PIP Validation Results

PIP Validation Elements	Validation Results
Selected Topic	Met
Study Question	Met
Indicators	Met
Population	Met
Sampling Methods	Met
Data Collection Procedures	Met
Interpretation of Study Results	Met
Improvement Strategies	Met

PIP= performance improvement project.

2019 Financial Withhold

IMCare achieved 13 points (of 99 points) for the F&C-MA and MNCare programs and achieved 89.54 points (of 90 points) for the MSHO and MSC+ programs. **Table 30** displays the results of the 2019 Financial Withhold, including performance measures, point values, and points earned by IMCare.

Table 30: IMCare 2019 Financial Withhold

Performance Measure	Point Value	Points Earned
F&C-MA and MNCare		
Annual Dental Visit: Age stratification 1-20 years	55	0
Annual Dental Visit: Age stratification 21-64 years	30	0
Provider Network Equity: FFS vs. MCO	10	10
Repeat Deficiencies on the MDH QAE	2	2
Emergency Department (ED) Utilization Rate	1	1
Hospital Admission Rate	1	0
Hospital 30-Day Readmission Rate	Small Population	Small Population
TOTAL	**99**	**13**
MSHO and MSC+		
Repeat Deficiencies on the MDH QAE	15	15
Care Plan Audit	15	15
Initial Health Risk Screening/Assessment	30	30
Stakeholder Group Reporting	15	15
Annual Dental Visit: Age 65+	15	14.54
TOTAL	**90**	**89.54**

Note: The F&C-MA and MNCare Hospital 30-Day Readmission Rate was eliminated from the point calculation due to low claims rate in the county.

Annual Quality Assurance Work Plan for 2019

IMCare developed a quality assurance work plan compliant with Minnesota Administrative Rule 4685.1130. Activities reported in the work plan are organized by topics, and cover many areas of care and services. Some of these include network adequacy and provider accessibility, credentialing, enrollee and provider satisfaction, and populations with special health care needs, as well as performance improvement projects and focused studies. The work plan details the activities, objectives and goals, tasks for completion, outcome measures, data sources, responsible staff, timelines, and progress for each activity consistently throughout.

Evaluation of the 2019 Annual Quality Assessment and Performance Improvement Program

In 2019, IMCare made many strides towards quality improvement with a strong focus on staff, provider and enrollee education. IMCare provided enrollee education through community outreach, monthly education sessions, the IMCare website and biannual newsletters. IMCare staff also provided enrollees with a wealth of information through activities of care coordination, disease management and complex case management. Education ranged from ongoing IMCare quality programs and navigating the IMCare network, to appropriate preventative care. Quality improvement goals were based on survey results, utilization and claims data, HEDIS data, QAE and TCA.

Clinical Practice Guidelines

IMCare recognizes the following sources for clinical practice guidelines:

- UpToDate[36]
  - Overview of Medical Care in Adults with Diabetes Mellitus
  - Preventive care in Adults: Recommendations
  - Geriatric Health Maintenance
  - Screening Test in Children and Adolescents
  - Guidelines for Adolescent Preventive Services
  - Prenatal Care: Initial Assessment
  - Prenatal Care: Second and Third Trimesters

Quality Improvement Program Website[37]

IMCare's quality improvement program website provides links to the annual quality improvement program evaluations for 2017, 2018 and 2019.

Performance Measures

Information Systems Capabilities Assessment

The 2020 HEDIS FAR for MY 2019 produced by MetaStar indicated that IMCare met all of the requirements to successfully report HEDIS data to DHS. **Table 31** displays the results of the IS audit.

Table 31: IMCare Compliance with Information System Standards

Information System Standard	Review Result
1.0 Medical Services Data	Met
2.0 Enrollment Data	Met
3.0 Practitioner Data	Met
4.0 Medical Record Review Processes	Met
5.0 Supplemental Data	Met
6.0 Data Preproduction Processing	Met
7.0 Data Integration and Reporting	Met

[36] UpToDate Website: https://www.uptodate.com/contents/evidence-based-medicine
[37] IMCare Quality Improvement Program website:

HEDIS – Quality, Timeliness and Access

Due to the coronavirus disease of 2019 (COVID-19) outbreak and in accord with NCQA recommendations, DHS and MDH allowed Medicaid MCOs to request a waiver to report audited HEDIS MY 2018 hybrid rates if they were not able to complete HEDIS MY 2019 hybrid medical record chart reviews according to NCQA technical specifications.

IMCare did not apply for this waiver and reported HEDIS MY 2019 hybrid rates to DHS. These rates, along with rates for administrative measures calculated by DHS are in Table **32**. The results of the MCO's Measure Matrix analysis are presented in **Figure 7**.

Table 32: IMCare HEDIS Performance – Reporting Years 2018, 2019 and 2020

HEDIS Measures	IMCare 2018 HEDIS MY 2017	IMCare 2019 HEDIS MY 2018	IMCare 2020 HEDIS MY 2019	*QC 2020* National Medicaid Benchmark Met/Exceeded	Statewide Average MY 2019
F&C-MA					
Adolescent Well-Care Visit (12-21 Years)[1]	39.2%	40.4%	51.1%	33.33rd	49.2%
Adult BMI Assessment[1]	92.2%	95.1%	91.0%	33.33rd	93.0%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	83.8%	84.0%	83.8%	75th	82.8%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	88.1%	87.4%	86.5%	50th	86.8%
Annual Dental Visit for Children (2-18 Years)	-	70.0%	68.4%	75th	57.4%
Annual Dental Visit for Adults (19-64 Years)	-	46.6%	44.8%	No Benchmark	37.4%
Breast Cancer Screening (50-64 Years)[2]	52.6%	60.1%	60.2%	50th	59.8%
Cervical Cancer Screening (24-64 Years)[2]	53.3%	52.8%	50.3%	10th	56.3%
Childhood Immunization Status: Combo 3 (2 Years)[1]	74.8%	71.4%	64.3%	10th	67.7%
Children and Adolescents' Access to PCPs (12-24 Months)[2]	96.5%	96.6%	96.9%	66.67th	96.3%
Children and Adolescents' Access to PCPs (25 Months-6 Years)[2]	88.7%	90.6%	90.5%	66.67th	88.5%
Children and Adolescents' Access to PCPs (7-11 Years)[2]	89.2%	91.0%	91.7%	50th	91.7%
Children and Adolescents' Access to PCPs (12-19 Years)[2]	91.7%	92.2%	91.7%	66.67th	91.9%
Chlamydia Screening in Women (16-24 Years)[2]	42.5%	49.2%	44.7%	10th	55.1%
Comprehensive Diabetes Care: Eye Exam (18-64 Years)[1]	61.2%	61.9%	55.4%	25th	67.5%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1]	90.5%	91.7%	94.3%	90th	93.1%
Controlling High Blood Pressure[1]	67.4%	75.1%	75.0%	95th	73.3%
Well-Child Visits in the First 15 Months of Life (6+ Visits)[2]	59.7%	56.5%	64.2%	25th	64.2%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life[2]	60.9%	59.7%	64.7%	10th	65.9%

[1] Rate calculated by the MCO using the hybrid methodology.
[2] Rate calculated by DHS using the administrative methodology.
MY= measurement year; QC= NCQA 2020 Quality Compass MY 2019; BMI= body mass index; PCPs= primary care providers.
Note 1: The NCQA benchmark used for the Annual Dental Visit for Children represents an expanded age group (2-20 year olds).

Table 32: IMCare HEDIS Performance – Reporting Years 2018, 2019 and 2020 (Continued)

HEDIS Measures	IMCare 2018 HEDIS MY 2017	IMCare 2019 HEDIS MY 2018	IMCare 2020 HEDIS MY 2019	*QC 2020* National Medicaid Benchmark Met/Exceeded	Statewide Average MY 2019
MNCare					
Adolescent Well-Care Visit (12-21 Years)[1]	Small Sample	Small Sample	Small Sample	Not Applicable	40.4%
Adult BMI Assessment[1]	91.9%	95.7%	92.0%	50th	90.0%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	81.4%	82.9%	88.3%	95th	82.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	90.4%	90.3%	91.0%	90th	88.4%
Annual Dental Visit for Children (2-18 Years)	-	Small Sample	75.0%	95th	54.9%
Annual Dental Visit for Adults (19-64 Years)	-	55.3%	54.4%	No Benchmark	40.0%
Breast Cancer Screening (50-64 Years)[2]	68.3%	63.8%	62.1%	66.67th	64.9%
Cervical Cancer Screening (24-64 Years)[2]	52.2%	57.8%	59.4%	33.33rd	54.7%
Children and Adolescents' Access to PCPs (12-24 Months)[2]	Small Sample	Small Sample	Small Sample	Not Applicable	96.9%
Children and Adolescents' Access to PCPs (12-19 Years)[2]	Small Sample	Small Sample	Small Sample	Not Applicable	89.4%
Chlamydia Screening in Women (16-24 Years)[2]	Small Sample	Small Sample	Small Sample	Not Applicable	55.9%
Comprehensive Diabetes Care: Eye Exam (18-64 Years)[1]	65.0%	64.4%	54.6%	33.33rd	67.5%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1]	95.0%	93.3%	100.0%	95th	96.9%
Controlling High Blood Pressure[1]	67.4%	76.8%	75.0%	95th	75.4%

[1] Rate calculated by the MCO using the hybrid methodology.

[2] Rate calculated by DHS using the administrative methodology.

MY=measurement year; QC= NCQA 2020 Quality Compass MY 2019; BMI= body mass index.

Note 1: The NCQA benchmark used for the Annual Dental Visit for Children represents an expanded age group (2-20 year olds).

Table 32: IMCare HEDIS Performance – Reporting Years 2018, 2019 and 2020 (Continued)

HEDIS Measures	IMCare 2018 HEDIS MY 2017	IMCare 2019 HEDIS MY 2018	IMCare 2020 HEDIS MY 2019	*QC 2020* National Medicaid Benchmark Met/Exceeded	Statewide Average MY 2019
MSHO					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)[2]	98.2%	98.5%	98.2%	95th	98.3%
Breast Cancer Screening (65-74 Years)[2]	60.6%	67.3%	73.5%	95th	64.6%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)[2]	94.4%	100.0%	100.0%	95th	92.2%
MSC+					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)[2]	89.9%	88.6%	90.0%	50th	88.1%
Breast Cancer Screening (65-74 Years)[2]	31.6%	57.5%	52.2%	10th	40.4%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)[2]	91.7%	83.9%	83.3%	<10th	65.8%

[1] Rate calculated by the MCO using the hybrid methodology.

[2] Rate calculated by DHS using the administrative methodology.

MY= measurement year; QC= NCQA 2020 Quality Compass MY 2019; BMI= body mass index; PCPs= primary care providers.

Figure 7: IMCare 2020 HEDIS Measure Matrix

2018 – 2019 Rate Change	Statewide Average Statistical Significance Comparison		
	Below Average	**Statewide Average**	**Above Average**
	C	**B** ▪ Adolescent Well-Care Visit (F&C-MA)	**A**
	D ▪ Cervical Cancer Screening (F&C-MA) ▪ Comprehensive Diabetes Care-Eye Exam (F&C-MA, MNCare) ▪ Chlamydia Screening in Women (F&C-MA)	**C** ▪ Adult BMI Assessment (F&C-MA, MNCare) ▪ Breast Cancer Screening (F&C-MA, MSC+, MSHO, MNCare) ▪ Controlling High Blood Pressure (F&C-MA, MNCare) ▪ Cervical Cancer Screening (MNCare) ▪ Comprehensive Diabetes Care-HbA1c Testing (F&C-MA) ▪ Childhood Immunization Status-Combo 3 (F&C-MA) ▪ Well-Child Visit in the First 15 Months of Life-6+ Visits (F&C-MA) ▪ Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (F&C-MA)	**B** ▪ Annual Dental Visit-Adult (F&C-MA, MNCare) ▪ Annual Dental Visit-Children (F&C-MA) ▪ Comprehensive Diabetes Care-HbA1c Testing (MNCare)
	F	**D**	**C**

Key to the Measure Matrix

A Notable performance. MCO may continue with internal goals.
B MCOs may identify continued opportunities for improvement, but no required action.
C MCOs should identify opportunities for improvement, but no immediate action required.
D Conduct root cause analysis and develop action plan.
F Conduct root cause analysis and develop action plan.

Table 33: IMCare CAHPS Performance – 2018, 2019 and 2020

CAHPS Measures	IMCare CAHPS 2018	IMCare CAHPS 2019	IMCare CAHPS 2020	*QC 2020* National Medicaid Benchmark Met/Exceeded	2020 Statewide Average
F&C-MA					
Getting Needed Care*	87.0%	84.2%	79.7%	10th	81.7%
Getting Care Quickly*	81.4%	79.4%	85.0%	66.67th	83.8%
How Well Doctors Communicate*	96.3%	94.6%	93.5%	50th	94.7%
Customer Service*	83.9%	82.6%	91.8%	75th	88.3%
Shared Decision Making*	86.1%	79.7%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	48.6%	48.8%	50.0%	<10th	52.5%
Rating of Personal Doctor**	71.3%	74.1%	67.1%	25th	71.6%
Rating of Specialist Seen Most Often**	74.2%	54.5%	58.8%	<10th	63.7%
Rating of Health Plan**	56.9%	53.8%	55.5%	10th	56.8%
MNCare					
Getting Needed Care*	86.1%	86.3%	84.6%	50th	83.3%
Getting Care Quickly*	87.7%	86.2%	88.5%▲	95th	83.2%
How Well Doctors Communicate*	96.1%	95.8%	97.0%	95th	96.9%
Customer Service*	89.8%	82.7%	86.8%	10th	88.6%
Shared Decision Making*	83.9%	76.7%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	51.9%	50.5%	49.0%	<10th	52.2%
Rating of Personal Doctor**	69.2%	71.1%	70.1%	50th	71.5%
Rating of Specialist Seen Most Often**	65.6%	65.5%	58.7%	<10th	62.7%
Rating of Health Plan**	53.8%	56.1%	47.8%	<10th	50.9%

F&C-MA Response Rate = 24.33%. Sample Size = 1,350. Complete Surveys = 326.
MNCare Response Rate = 35.30%. Sample Size = 1,350. Complete Surveys = 467.
* Measure represents the percent of members who responded "yes," "usually" or "always."
** Ratings range from 0 to 10. This measure represents the percent of members who responded "9" or "10."
▲ Statistically significantly higher than the Total MCO program average.

Table 33: IMCare CAHPS Performance – 2018, 2019 and 2020 (Continued)

CAHPS Measures	IMCare CAHPS 2018	IMCare CAHPS 2019	IMCare CAHPS 2020	*QC 2020* National Medicaid Benchmark Met/Exceeded	2020 Statewide Average
MSC+					
Getting Needed Care*	88.6%	89.5%	87.9%	75th	86.1%
Getting Care Quickly*	90.9%	88.9%	87.7%	90th	86.2%
How Well Doctors Communicate*	96.3%	95.4%	94.0%	50th	94.9%
Customer Service*	94.4%	92.3%	91.4%	75th	90.1%
Shared Decision Making*	78.1%	80.2%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	60.3%	60.7%	57.7%	50th	56.7%
Rating of Personal Doctor**	77.0%	73.7%	72.0%	66.67th	74.3%
Rating of Specialist Seen Most Often**	72.6%	68.7%	72.2%	50th	71.6%
Rating of Health Plan**	71.9%	64.0%	64.4%	50th	62.4%

MSC+ Response Rate = 56.18%. Sample Size = 1,224. Complete Surveys = 664.

* Measure represents the percent of members who responded "yes," "usually" or "always."

** Ratings range from 0 to 10. This measure represents the percent of members who responded "9" or "10."

IMCare Findings and Recommendations

Strengths

- **Compliance –** IMCare was fully compliant with the standards of *Title 42 CFR Part 438 Managed Care Subpart D* and *Title 42 CFR § 438.330*.
- **PIP –** IMCare designed and conducted a PIP that met the standards of *Title 42 CFR 438.330(d)* and *Section 7.2* of the DHS model contract for MCOs.
- **ISCA –** IMCare met all IS requirements of the HEDIS Compliance Audit and successfully reported HEDIS data.
- **Member Satisfaction (CAHPS) –** IMCare achieved a significantly higher score than the statewide average for the following program and measure:
    - MNCare: Getting Care Quickly

Opportunities for Improvement

- **Compliance –**
    - **QAE:** IMCare received three (3) mandatory improvements and two (2) deficiencies for compliance with state standards.
    - **TCA:** IMCare received three (3) "not met" designations for compliance with state requirements.
- **Financial Withhold** – IMCare did not earn full points for the F&C-MA, MNCare, MSHO, MSC+ and SNBC programs. The MCO did not meet the target goal for the following measures:
    - F&C-MA and MNCare
        - Annual Dental Visit for Children (aged 1-20 years)
        - Annual Dental Visit for Adults (aged 21-64 years)
        - Hospital 30-Day Readmission Rate
    - MSHO and MSC+
        - Annual Dental Visit Rate (aged 18-64 years)
- **Quality of Care (HEDIS) –** IMCare demonstrates an opportunity for improvement in the following areas of care:
    - F&C-MA
        - Cervical Cancer Screening
        - Comprehensive Diabetes Care-Eye Exam
        - Chlamydia Screening in Women
    - MNCare
        - Comprehensive Diabetes Care-Eye Exam

Recommendations

- **Financial Withhold** –
  - IMCare should consider conducting adequacy evaluations of its dental provider network more frequently. IMCare should consider collaborating with the other MCOs to develop a broader plan for addressing the shortage of dental providers across the state. IMCare should also consider working with primary care providers to provide fluoride varnish as part of routine checkups.
  - Concerning hospital readmissions, IMCare should consider establishing a formal transition of care program for members discharged from the hospital. IMCare should identify potential partnerships within the Minnesota healthcare setting to support members post- discharge.
- **Quality of Care (HEDIS) –** As certain aspects of women's health continues to be an opportunity for improvement, IMCare should establish a more aggressive approach to educating its female membership on the importance of screenings, educating providers on clinical guidelines and addressing any gaps in the provider network that may present a barrier to its membership accessing needed care.

MEDICA

CORPORATE PROFILE

Medica HMO contracts with DHS to provide services to enrollees in the MSC+, MSHO and SNBC programs. As of December 2019, enrollment totaled 25,644, accounting for 2.8% of the entire MHCP population. **Table 34** displays Medica's enrollment as of December 2019.

Table 34: Medica Enrollment as of December 2019

Program	Enrollment (as of December 2019)
MSC+	4,040
MSHO	10,436
SNBC	11,168
Total Enrollment	**25,644**

Source: Minnesota Health Care Enrollment Totals December 2019 Report

QUALITY ASSURANCE EXAMINATION AND TRIENNIAL COMPLIANCE ASSESSMENT

MDH conducted the most recent QAE and TCA on October 2, 2017 through October 6, 2017. The examination period covered January 1, 2015 to August 31, 2017, while the file review period covered January 1, 2016 to August 31, 2017. The MCO received two (2) mandatory improvements for the QAE and one (1) "not met" designation for the TCA. However, the results of the TCA also concluded that Medica was compliant with the standards described in 42 CFR 438 Subpart D. **Table 35** presents a summary of these findings.

Table 35: Medica Compliance Review Results for Part 438 Subpart D and QAPI Standards

42 CFR 438 Subpart D and Quality Assessment and Performance Improvement Program Standards	Review Determination (Met or Not Met)
Access Standards 438.206 Availability of Services 438.207 Assurances of Adequate Capacity and Services 438.208 Coordination and Continuity of Care 438.210 Coverage and Authorization of Service	Met
Structure and Operations Standards 438.214 Provider Selection 438.224 Confidentiality and Accuracy of Enrollee Records 438.228 Grievance Systems 438.230 Sub Contractual Relationships and Delegation	Met
Measurement Improvement Standards 438.236 Practice Guidelines Program 438.242 Health Information System	Met
Written Quality Assurance Plan (Quality Program Description) 438.330 Quality Assessment and Performance Improvement Program	Met

CFR= Code of Federal regulations

PERFORMANCE IMPROVEMENT PROJECTS

DHS's validation of Medica's 2019 PIP confirmed its compliance with the standards of *Title 42 CFR 438.330(d)* and *Section 7.2 of* the DHS model contract for MCOs.

Medica focused on the MSHO and SNBC programs in their PIP interventions. Medica collaborated with their pharmacy benefits manager, CVS, to create the Enhanced Safety and Monitoring Program. This program identified high-risk or inappropriate prescribing behaviors and alerted necessary parties to the problem. This resulted in targeted communications to individual MSHO members, restrictions on quantities of certain medications available under certain conditions, and follow-up with the prescriber. When appropriate, the prescriber was presented with a training toolkit on opioids, pain management, and current guidelines; or, the prescriber was granted the opportunity to engage in consultations or peer-to-peer telephonic outreach sessions with pain specialists. Medica's approach also included the use of the Restricted Recipient Program, Clinical Quality Reviews for high opioid prescribers, education on proper medication disposal, and utilization of care coordination and alternative pain management therapies.

Table 36 presents 2017-2019 new chronic user rates for Medica and the state. As this is the first reporting cycle looking back on the first year of the PIP, there is not sufficient information to draw specific conclusions.

Table 36: Medica PIP Rates – New Chronic Users

Reporting Year	Medica Rate	Statewide Average Rate
F&C-MA and MNCare		
2017 (baseline)	2.7%	3.5%
2018 (intervention year 1)	No F&C-MA or MNCare Enrollment	2.7%
2019 (intervention year 2)	No F&C-MA or MNCare Enrollment	2.1%
MSHO and MSC+		
2017 (baseline)	19.3%	18.5%
2018 (intervention year 1)	33.1%	22.9%
2019 (intervention year 2)	14.1%	14.9%
SNBC		
2017 (baseline)	6.6%	9.9%
2018 (intervention year 1)	7.5%	8.84%
2019 (intervention year 2)	10.5%	7.5%

PIP= performance improvement project.

Table 37 displays validations results for the Medica PIP.

Table 37: Medica PIP Validation Results

PIP Validation Elements	Validation Results
Selected Topic	Met
Study Question	Met
Indicators	Met
Population	Met
Sampling Methods	Met
Data Collection Procedures	Met
Interpretation of Study Results	Met
Improvement Strategies	Met

PIP= performance improvement project.

2019 Financial Withhold

Medica achieved 82.26 points (of 90 points) for the MSHO and MSC+ programs, and 51.76 points (of 60 points) for the SNBC program. **Table 38** displays the results of the 2019 Financial Withhold, including performance measures, point values, and points earned by Medica.

Table 38: Medica 2019 Financial Withhold

Performance Measure	Point Value	Points Earned
MSHO and MSC+		
Repeat Deficiencies on the MDH QAE	15	15
Care Plan Audit	15	15
Initial Health Risk Screening/Assessment	30	30
Stakeholder Group Reporting	15	15
Annual Dental Visit: Age 65+	15	7.26
TOTAL	**90**	**82.26**
SNBC		
Repeat Deficiencies on the MDH QAE	15	15
Compliance with Service Accessibility Requirements	15	15
Stakeholder Group Reporting	15	15
Annual Dental Visit: Age 18-64	15	6.76
TOTAL	**60**	**51.76**
QAE: Quality Assurance Exam		

Annual Quality Assurance Work Plan for 2019

Medica's quality assurance work plan, compliant with Minnesota Administrative Rule 4685.1130, outlines the significant, measureable quality improvement activities planned. Activities were meant to address one or more of the following areas: clinical quality, service quality/member experience, provider quality, patient safety, and regulatory/accreditation requirements. Activities are also categorized as assessment/research, design/development, implementation, improvement, or evaluation. For each project, a description of the activity, the project lead, objective and rationale, expected quality improvement impact, milestones, and outcomes are provided consistently throughout the work plan.

Evaluation of the 2019 Annual Quality Assessment and Performance Improvement Program

Medica regularly monitors numerous continuous quality measures. These ongoing monitors help Medica staff identify potential problems and plan quality improvement initiatives to address them. Key performance monitors include, but are not limited to appointment access, call center performance, care coordination, clinical and service quality review, delegated quality improvement/delegation oversight, HEDIS/CAHPS data maintenance, member appeals, network adequacy, quality of care complaints and QI program documents. By year-end, the 2019 QI Work Plan featured a total of 16 active initiatives. Medica fully met or exceeded eight target goals and partially met two others. Three goals were not met. QI Initiatives included focusing on chronic opioid use, improving the percentage of health risk assessments performed and documented, medical care satisfaction reported by MSHO members', coordination of programs and services, dental visit rates, service staff member experience, CAHPS, Medicare Health Outcomes Survey (HOS) and HOS – Modified (HOS-M) performance and response rates, HEDIS

performance and quality of care investigations. Medica also assessed their ability to complete and document reassessments within 30 days of member enrollment, document MSHO and SNBC enhanced products within 365 days, identify and implement process improvement ideas, implement and monitor action plans for survey preparation and monitor all Medicare part C and D overturns.

CLINICAL PRACTICE GUIDELINES

Medica recognizes the following sources for clinical practice guidelines:

- AAP
  - Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents
  - Guidelines for Adolescent Depression in Primary Care: Part I. Assessment and Initial Management
  - Guidelines for Adolescent Depression in Primary Care: Part II. Treatment and Ongoing Management
- ADA
  - Diabetes care
- APA
  - Bipolar Disorder: Adults
  - Schizophrenia
- American College of Cardiology[38] (ACC) and AHA
  - Cholesterol management
  - Management of heart failure
  - Prevention, detection, evaluation, and management of high blood pressure in adults
  - Lifestyle management to reduce cardiovascular risk
  - Management of overweight and obesity in adults
- American College of Physicians[39] (ACP)
  - Prevention and treatment of osteoporosis
- ASAM
  - Substance use disorders
- CDC
  - Prescribing opioids for chronic pain
- Global Initiative for Chronic and Obstructive Lung Disease
  - Chronic obstructive lung disease
- Minnesota DHS
  - Child and Teen Checkups
- NHLBI
  - Screening, prevention, diagnosis and treatment of asthma

[38] American College of Cardiology Website: https://www.acc.org/#sort=%40commonsortdate%20descending
[39] American College of Physicians Website: https://www.acponline.org/

- Tobacco Use and Dependence Guideline Panel
    - Treating tobacco use and dependence
- USPSTF
    - Preventive services

Quality Improvement Program Website[40]

Medica's quality improvement program website is organized by the following categories: program purpose, program scope, customer driven quality strategy, identifying opportunities for improvement, QI models, annual work plan, program evaluation, and program staff and governance. Medica provides descriptions of each category absent of access to data and available reporting.

Performance Measures

Information Systems Capabilities Assessment

The 2020 HEDIS FAR for MY 2019 produced by Attest Health Care Advisors indicated that Medica met all of the requirements to successfully report HEDIS data to DHS. **Table 39** displays the results of the IS audit.

Table 39: Medica Compliance with Information System Standards

Information System Standard	Review Result
1.0 Medical Services Data	Met
2.0 Enrollment Data	Met
3.0 Practitioner Data	Met
4.0 Medical Record Review Processes	Met
5.0 Supplemental Data	Met
6.0 Data Preproduction Processing	Met
7.0 Data Integration and Reporting	Met

[40] Medica Quality Improvement Program Website: https://www.medica.com/providers/quality-and-cost-programs/quality-improvement-program

HEDIS – Quality, Timeliness and Access

Due to the coronavirus disease of 2019 (COVID-19) outbreak and in accord with NCQA recommendations, DHS and MDH allowed Medicaid MCOs to request a waiver to report audited HEDIS MY 2018 hybrid rates if they were not able to complete HEDIS MY 2019 hybrid medical record chart reviews according to NCQA technical specifications.

Medica's waiver to report HEDIS MY 2018 hybrid rates for HEDIS MY 2019 was approved. All HEDIS rates in **Table 40** were administratively calculated by DHS.

Medica HEDIS rates are displayed in **Table 40**. The results of the MCO's Measure Matrix analysis are presented in **Figure 8**.

Table 40: Medica HEDIS Performance – Reporting Years 2018, 2019 and 2020

HEDIS Measures	Medica 2018 HEDIS MY 2017	Medica 2019 HEDIS MY 2018	Medica 2020 HEDIS MY 2019	*QC 2020* National Medicaid Benchmark Met/Exceeded	Statewide Average MY 2019
MSHO					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)	98.5%	98.1%	98.5%	95th	98.3%
Breast Cancer Screening (65-74 Years)	57.8%	60.9%	62.1%	66.67th	64.6%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)	94.2%	93.3%	93.0%	90th	92.2%
MSC+					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)	93.8%	92.4%	93.0%	75th	88.1%
Breast Cancer Screening (65-74 Years)	27.9%	25.1%	23.9%	<10th	40.4%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)	62.7%	51.4%	43.9%	<10th	77.1%
SNBC					
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)	91.6%	90.4%	91.3%	95th	92.7%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)	96.2%	96.1%	95.9%	95th	96.4%
Breast Cancer Screening (50-64 Years)	36.1%	34.5%	33.2%	<10th	53.3%
Cervical Cancer Screening (24-64 Years)	42.7%	41.2%	33.1%	<10th	41.3%
Chlamydia Screening in Women (16-24 Years)	47.3%	47.2%	35.5%	<10th	41.1%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)	72.4%	59.1%	58.0%	<10th	80.6%

MY= measurement year; QC= NCQA 2020 Quality Compass MY 2019; PCPs= primary care providers.
All rates were calculated by DHS using the administrative methodology.
Note 1: HEDIS hybrid rates are not reported by the MCO because of NCQA reporting changes due to COVID-19. See note on pg. 19. HEDIS Hybrid measures include Adult BMI Assessment, Comprehensive Diabetes Care: Eye Exam.
Note 2: The measure 'Medication Management for People With Asthma (5-64 years)' is no longer included in this report.

Figure 8: Medica 2020 HEDIS Measure Matrix

	Statewide Average Statistical Significance Comparison		
2018 – 2019 Rate Change	**Below Average**	**Statewide Average**	**Above Average**
	C	**B**	**A**
	D ▪ Breast Cancer Screening (MSC+, SNBC) ▪ Comprehensive Diabetes Care-Eye Exam (SNBC)	**C** ▪ Breast Cancer Screening (MSHO) ▪ Comprehensive Diabetes Care-HbA1c Testing (MSHO)	**B**
	F ▪ Cervical Cancer Screening (SNBC) ▪ Comprehensive Diabetes Care-HbA1c Testing (MSC+)	**D**	**C**

Key to the Measure Matrix

A	Notable performance. MCO may continue with internal goals.
B	MCOs may identify continued opportunities for improvement, but no required action.
C	MCOs should identify opportunities for improvement, but no immediate action required.
D	Conduct root cause analysis and develop action plan.
F	Conduct root cause analysis and develop action plan.

Table 41: Medica CAHPS Performance – 2018, 2019 and 2020

CAHPS Measures	Medica CAHPS 2018	Medica CAHPS 2019	Medica CAHPS 2020	*QC 2020* National Medicaid Benchmark Met/Exceeded	2020 Statewide Average
MSC+					
Getting Needed Care*	84.9%	84.6%	83.5%	50th	86.1%
Getting Care Quickly*	84.8%	84.4%	86.8%	75th	86.2%
How Well Doctors Communicate*	94.3%	96.0%	94.2%	66.67th	94.9%
Customer Service*	93.6%	85.7%	88.1%	25th	90.1%
Shared Decision Making*	77.1%	80.7%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	60.8%	57.1%	56.2%	33.33rd	56.7%
Rating of Personal Doctor**	80.7%	77.6%	76.0%	90th	74.3%
Rating of Specialist Seen Most Often**	73.4%	68.4%	73.1%	66.67th	71.6%
Rating of Health Plan**	67.6%	65.3%	63.1%	50th	62.4%
SNBC					
Getting Needed Care*	82.4%	83.8%	86.5%	75th	83.6%
Getting Care Quickly*	80.2%	86.7%	85.3%	66.67th	84.7%
How Well Doctors Communicate*	92.6%	93.4%	93.8%	50th	93.9%
Customer Service*	88.7%	89.5%	89.8%	50th	89.5%
Shared Decision Making*	79.7%	84.7%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	54.1%	52.6%	60.3%▲	66.67th	53.0%
Rating of Personal Doctor**	71.8%	72.1%	79.8%▲	95th	72.3%
Rating of Specialist Seen Most Often**	66.0%	63.4%	68.9%	33.33rd	66.9%
Rating of Health Plan**	58.5%	60.4%	62.4%	33.33rd	58.3%

MSC+ Response Rate = 39.53%. Sample Size = 1,350. Complete Surveys = 485.
SNBC Response Rate = 31.98%. Sample Size = 1,350. Complete Surveys = 416.
* Measure represents the percent of members who responded "yes," "usually" or "always."
** Ratings range from 0 to 10. This measure represents the percent of members who responded "9" or "10."
▲ Statistically significantly higher than the Total MCO program average.

MEDICA FINDINGS AND RECOMMENDATIONS

Strengths

- **Compliance –** Medica was fully compliant with the standards of *Title 42 CFR Part 438 Managed Care Subpart D* and *Title 42 CFR § 438.330*.
- **PIP –** Medica designed and conducted a PIP that met the standards of *Title 42 CFR 438.330(d)* and *Section 7.2* of the DHS model contract for MCOs.
- **ISCA –** Medica met all IS requirements of the HEDIS Compliance Audit and successfully reported HEDIS data.
- **Member Satisfaction (CAHPS) –** Medica achieved a significantly higher score than the statewide average for the following program and measures:
    - SNBC: Rating of All Health Care and Rating of Personal Doctor

Opportunities for Improvement

- **Compliance –**
    - **QAE:** Medica received two (2) mandatory improvements for compliance with state standards.
    - **TCA:** Medica received one (1) "not met" designation for compliance with state requirements.
- **Financial Withhold** – Medica did not earn full points for the MSHO, MSC+ and SNBC programs. The MCO did not meet the target goal for the following measures:
    - MSHO and MSC+
        - Annual Dental Visit Rate (aged 65+ years)
    - SNBC
        - Annual Dental Visit Rate (aged 18-64 years)
- **Quality of Care (HEDIS)** –
    - MSC+
        - Breast Cancer Screening
        - Comprehensive Diabetes Care-HbA1c Testing
    - SNBC
        - Breast Cancer Screening
        - Comprehensive Diabetes Care-HbA1c Testing
        - Cervical Cancer Screening

Recommendations

- **Financial Withhold –** Medica should determine if there are gaps in its dental network preventing its members from accessing care as needed. Medica should consider enhancing its member education and outreach program.
- **Quality of Care (HEDIS) –** Medica should enhance its current strategy for improving women's health with member-specific interventions around education and how to access to services.

PRIMEWEST HEALTH

CORPORATE PROFILE

Organized through a Joint Powers Board (JPB) of thirteen (13) local county governments as a CBP, PrimeWest Health is a publicly funded MCO. The MCO began enrollment in July 2003 for the F&C-MA, MNCare, MSHO, MSC+ and SNBC programs. PrimeWest Health maintains the Commendable level of accreditation by NCQA under the Health Plan Accreditation status for its Medicaid lines of business. As of December 2019, enrollment totaled 40,539, accounting for 4.4% of the entire MHCP population. **Table 42** displays PrimeWest Health's enrollment as of December 2019.

Table 42: PrimeWest Health Enrollment as of December 2019

Program	Enrollment (as of December 2019)
F&C-MA	32,530
MNCare	3,072
MSC+	852
MSHO	1,885
SNBC	2,169
Total Enrollment	**40,539**

Source: Minnesota Health Care Enrollment Totals December 2019 Report.

QUALITY ASSURANCE EXAMINATION AND TRIENNIAL COMPLIANCE ASSESSMENT

MDH conducted the most recent QAE and TCA on July 17, 2017 through July 20, 2017. The examination period covered November 1, 2014 to March 31, 2017, while the file review period covered May 1, 2016 to April 30, 2017. The MCO received a total of four (4) mandatory improvements for the QAE and four (4) "not met" designations for the TCA. The mid-cycle review (February 2019) conducted on the corrective action plan submitted by PrimeWest Health stated that PrimeWest Health had addressed two (2) of the mandatory improvements. A resubmission of the PrimeWest Health corrective action plan for the remaining mandatory improvement was required by MDH.

The results of the TCA also concluded that PrimeWest Health was compliant with the standards described in 42 CFR 438 Subpart D. **Table 43** presents a summary of these findings.

Table 43: PrimeWest Health Compliance Review Results for Part 438 Subpart D and QAPI Standards

42 CFR 438 Subpart D and Quality Assessment and Performance Improvement Program Standards	Review Determination (Met or Not Met)
Access Standards 438.206 Availability of Services 438.207 Assurances of Adequate Capacity and Services 438.208 Coordination and Continuity of Care 438.210 Coverage and Authorization of Service	Met
Structure and Operations Standards 438.214 Provider Selection 438.224 Confidentiality and Accuracy of Enrollee Records 438.228 Grievance Systems 438.230 Sub Contractual Relationships and Delegation	Met
Measurement Improvement Standards 438.236 Practice Guidelines Program 438.242 Health Information System	Met
Written Quality Assurance Plan (Quality Program Description) 438.330 Quality Assessment and Performance Improvement Program	Met

CFR= Code of Federal Regulations.

PERFORMANCE IMPROVEMENT PROJECTS

DHS's validation of PrimeWest Health's 2019 PIP confirmed its compliance with the standards of *Title 42 CFR 438.330(d)* and *Section 7.2 of* the DHS model contract for MCOs.

PrimeWest Health focused their PIP on the Native American population they serve. Administrative interventions include changes to pharmacy allowances, based on guidance from the Universal Pharmacy Policy Workgroup. These changes expanded clinical justifications for opioids, limited refill eligibility to 90% usage, and introduced provider outreach in instances where opioids may not be the best treatment option for the patient. Provider-level interventions included increased outreach beyond the pharmacy-initiated interventions. Newsletter communications regarding the PIP, training seminars, presentations, and conferences were all leveraged to directly interact with providers and emphasize the importance and impact of the PIP. Finally, PrimeWest Health intervened with members directly through multiple mechanisms. PrimeWest Health's largest member serving pharmacy, Thrifty White Pharmacy, developed a pilot program wherein pharmacists engaged in point-of-sale patient education when an opioid was dispensed to a PrimeWest Health customer. PrimeWest Health also communicated directly to members through their member newsletter, emphasizing topics such as appropriate opioid use, safe disposal, and updates on the PIP, itself.

Table 44 presents 2017-2019 new chronic user rates for PrimeWest Health and the state. As this is the first reporting cycle looking back on the first year of the PIP, there is not sufficient information to draw specific conclusions.

Table 44: PrimeWest Health PIP Rates – New Chronic Users

Reporting Year	PrimeWest Health Rate	Statewide Average Rate
F&C-MA and MNCare		
2017 (baseline)	3.9%	3.5%
2018 (intervention year 1)	2.9%	2.7%
2019 (intervention year 2)	2.4%	2.1%
MSHO and MSC+		
2017 (baseline)	27.0%	18.5%
2018 (intervention year 1)	24.8%	22.9%
2019 (intervention year 2)	16.7%	14.9%
SNBC		
2017 (baseline)	11.6%	9.9%
2018 (intervention year 1)	7.82%	8.84%
2019 (intervention year 2)	6.4%	7.5%
PIP= performance improvement project.		

Table 45 displays validations results for the PrimeWest Health PIP.

Table 45: PrimeWest Health PIP Validation Results

PIP Validation Elements	Validation Results
Selected Topic	Met
Study Question	Met
Indicators	Met
Population	Met
Sampling Methods	Met
Data Collection Procedures	Met
Interpretation of Study Results	Met
Improvement Strategies	Met
PIP= performance improvement project.	

2019 Financial Withhold

PrimeWest Health achieved 4 points (of 100 points) for the F&C-MA and MNCare programs, 75 points (of 90 points) for the MSHO and MSC+ programs, and 45 points (of 60 points) for the SNBC program. **Table 46** displays the results of the 2019 Financial Withhold, including performance measures, point values, and points earned by PrimeWest Health.

Table 46: PrimeWest Health 2019 Financial Withhold

Performance Measure	Point Value	Points Earned
F&C-MA and MNCare		
Annual Dental Visit: Age stratification 1-20 years	55	0
Annual Dental Visit: Age stratification 21-64 years	30	0
Provider Network Equity: FFS vs. MCO	10	0
Repeat Deficiencies on the MDH QAE	2	2
Emergency Department (ED) Utilization Rate	1	1
Hospital Admission Rate	1	1
Hospital 30-Day Readmission Rate	1	0
TOTAL	**100**	**4**
MSHO and MSC+		
Repeat Deficiencies on the MDH QAE	15	15
Care Plan Audit	15	15
Initial Health Risk Screening/Assessment	30	30
Stakeholder Group Reporting	15	15
Annual Dental Visit: Age 65+	15	0
TOTAL	**90**	**75**
SNBC		
Repeat Deficiencies on the MDH QAE	15	15
Compliance with Service Accessibility Requirements	15	15
Service Accessibility (Dental)	15	15
Stakeholder Group Reporting	15	15
Annual Dental Visit: Age 18-64	15	0
TOTAL	**60**	**45**

FFS= fee-for-service; MCO= managed care organization;
QAE= Quality Assurance Exam.

Annual Quality Assurance Work Plan for 2019

PrimeWest Health submitted an annual QA work plan compliant with Minnesota Administrative Rule 4685.1130. The work plan clearly outlines each project's scope, objectives, responsible persons, and timelines to achieve project goals. The work plan also delineates when projects are in development, and when data will be collected, aggregated, reported, and analyzed. The work plan covers a variety of topics, including quality of services, availability of practitioners, accessibility of services, member experience, quality of clinical care, safety of clinical care, utilization management, and quality program administration. Additionally, the MCO clearly denotes activities that affect the safety of its members.

Evaluation of the 2019 Annual Quality Assessment and Performance Improvement Program

The PrimeWest Health strategic plan focuses on Triple Aim (population health, experience of care, and cost) and seeks to improve various quality outcomes, including (HEDIS®)1 and (CAHPS®)2 results. The outcomes for the three Quality of Clinical Care measures focusing on ER visits and inpatient admissions exceeded the pre-established goals. Other initiatives included their Disease Management (DM) programs which empowered members to better manage their care, their Population Health Management Program consisting of 4 processes, their community health improvement plans and an initiative focused on educating Senior Health Complete members on health care directives. The seven (7) HEDIS measures chosen for PrimeWest Health's strategic plan are Comprehensive Diabetes Care (CDC), Breast Cancer Screening (BCS), Childhood Immunization Status (CIS), Adolescent Well-Care Visits (AWC), Immunizations for Adolescents (IMA), Care for Older Adults (COA), and Medication Reconciliation Post-Discharge (MRP). This year, most populations met the goal of maintaining or improving in each area. Goals were met for Comprehensive Diabetes Care (CDC), Childhood Immunization Status (CIS), Immunizations for Adolescents (IMA) and Medication Reconciliation Post-Discharge (MRP). Additional projects included the Antidepressant Medication Management Chronic Conditions Improvement Project focusing on improving the AMM continuation phase measure and the 2018 Opioid PIP focusing on reducing the number of new chronic opioid users. To assess quality of service, focus studies were directed at potential improvements regarding chlamydia screenings amongst women, childhood immunizations and HEDIS incentives. PrimeWest Health also assessed network adequacy through multiple strategies and the availability of services via an Access to Care survey. To assess the safety of clinical care, PrimeWest Health monitored adverse events and quality of care grievances, member mortalities, falls amongst seniors, senior readmissions within 30 days discharge, potentially harmful misuse of medical services, new and existing technologies, use of over 4,000 Mg acetaminophen, medication therapy management, the use of potential drugs of abuse, the Special Needs Plan (SNP) Models of Care (MOCs), utilization management activities and health record reviews.

MCO Clinical Practice Guidelines

PrimeWest Health recognizes the following source for clinical practice guidelines:

- AACAP
    - Assessment and treatment of children and adolescents with attention deficit hyperactivity disorder
    - Assessment and treatment of children and adolescents with depressive disorders
- ACCF/AHA
    - Management of patients with chronic heart failure
- ACOG
    - Preconception, prenatal and postpartum care
- ADA
    - Standards of medical care in diabetes

- AHRQ
  - Treating tobacco use and dependence
- APA
  - Pharmacological treatment of patients with alcohol use disorder
- CDC
  - Immunization schedule for adults
  - Child and adolescent immunization schedules
- Journal of the American College of Cardiology (JACC)
  - Prevention, detection, evaluation and management of high blood pressure in adults
- ICSI
  - Diagnosis and management of chronic obstructive pulmonary disease
  - Treating adult depression
- MN DHS
  - Child and Teen Checkups
  - Children's Therapeutic Services and Supports
  - Dental services
  - Minnesota FFS and Managed Care Uniform Preferred Drug List
- NHLBI
  - Diagnosis and management of asthma
- USPSTF
  - Preventive services for adults, including breast cancer, cervical cancer, chlamydia screening and BMI assessment

Quality Improvement Program Website[41]

PrimeWest Health's quality improvement program website includes the MCO's quality objectives, which are to improve the health status of its members and to ensure access to high quality and safe health care services in the PrimeWest Health service area. The website is organized by annual reporting, appeals and grievances, HEDIS and PIPs and provides policy information for these areas.

Performance Measures

Information Systems Capabilities Assessment

The 2020 HEDIS FAR for MY 2019 produced by HSAG indicated that PrimeWest Health met all of the requirements to successfully report HEDIS data to DHS. **Table 47** displays the results of the IS audit.

[41] PrimeWest Health Quality Improvement Program Website: https://primewest.org/web/guest/quality;jsessionid=0B1596C61C6F321E50CB4BDAAC1F6FB9

Table 47: PrimeWest Health Compliance with Information System Standards

Information System Standard	Review Result
1.0 Medical Services Data	Met
2.0 Enrollment Data	Met
3.0 Practitioner Data	Met
4.0 Medical Record Review Processes	Met
5.0 Supplemental Data	Met
6.0 Data Preproduction Processing	Met
7.0 Data Integration and Reporting	Met

HEDIS – Quality, Timeliness and Access

Due to the coronavirus disease of 2019 (COVID-19) outbreak and in accord with NCQA recommendations, DHS and MDH allowed Medicaid MCOs to request a waiver to report audited 2019 HEDIS MY 2018 hybrid rates if they were not able to complete 2020 HEDIS MY 2019 hybrid medical record chart reviews according to NCQA technical specifications.

PrimeWest Health did not apply for this waiver and reported 2020 HEDIS MY 2019 hybrid rates to DHS. These rates, along with rates for administrative measures calculated by DHS are in **Table 48**. The results of the MCO's Measure Matrix analysis are presented in **Figure 9**.

Table 48: PrimeWest Health HEDIS Performance – Reporting Years 2018, 2019 and 2020

HEDIS Measures	PrimeWest Health 2018 HEDIS MY 2017	PrimeWest Health 2019 HEDIS MY 2018	PrimeWest Health 2020 HEDIS MY 2019	*QC 2020* National Medicaid Benchmark Met/Exceeded	Statewide Average MY 2019
F&C-MA					
Adolescent Well-Care Visit (12-21 Years)[1]	59.6%	52.1%	47.2%	10th	49.2%
Adult BMI Assessment[1]	90.0%	92.7%	93.4%	50th	93.0%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	85.3%	84.9%	85.0%	75th	82.8%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	87.4%	87.0%	87.9%	50th	86.8%
Annual Dental Visit for Children (2-18 Years)	-	57.7%	59.1%	33.33rd	57.4%
Annual Dental Visit for Adults (19-64 Years)	-	41.1%	41.4%	No Benchmark	37.4%
Breast Cancer Screening (50-64 Years)[2]	69.4%	68.3%	68.6%	75th	59.8%
Cervical Cancer Screening (24-64 Years) [2]	57.1%	56.2%	51.8%	10th	56.3%
Childhood Immunization Status: Combo 3 (2 Years)[1]	64.7%	67.4%	68.6%	33.33rd	67.7%
Children and Adolescents' Access to PCPs (12-24 Months)[2]	95.4%	95.6%	96.1%	50th	96.3%
Children and Adolescents' Access to PCPs (25 Months-6 Years)[2]	87.7%	87.2%	87.7%	33.33rd	88.5%
Children and Adolescents' Access to PCPs (7-11 Years)[2]	92.2%	90.4%	91.4%	50th	91.7%
Children and Adolescents' Access to PCPs (12-19 Years)[2]	93.7%	92.7%	92.9%	75th	91.9%
Chlamydia Screening in Women (16-24 Years)[2]	39.9%	40.9%	42.4%	<10th	55.1%
Comprehensive Diabetes Care: Eye Exam (18-64 Years)[1]	72.5%	71.1%	71.0%	90th	67.5%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1]	89.4%	90.4%	92.7%	90th	93.1%
Controlling High Blood Pressure[1]	68.6%	70.3%	72.3%	75th	73.3%
Well-Child Visits in the First 15 Months of Life (6+ Visits)[2]	60.3%	59.5%	61.9%	25th	64.2%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life[2]	56.7%	56.9%	58.9%	<10th	65.9%

[1] Rate calculated by the MCO using the hybrid methodology.
[2] Rate calculated by DHS using the administrative methodology.
MY= measurement year; QC= NCQA 2020 Quality Compass MY 2019; BMI= body mass index; PCPs= primary care providers.
Note 1: The NCQA benchmark used for the Annual Dental Visit for Children represents an expanded age group (2-20 year olds).

Table 48: PrimeWest Health HEDIS Performance – Reporting Years 2018, 2019 and 2020 (Continued)

HEDIS Measures	PrimeWest Health 2018 HEDIS MY 2017	PrimeWest Health 2019 HEDIS MY 2018	PrimeWest Health 2020 HEDIS MY 2019	*QC 2020* National Medicaid Benchmark Met/Exceeded	Statewide Average MY 2019
MNCare					
Adolescent Well-Care Visit (12-21 Years)[1]	56.4%	56.5%	40.7%	10th	40.4%
Adult BMI Assessment[1]	88.6%	88.8%	89.5%	33.33rd	90.0%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	85.8%	85.6%	84.1%	75th	82.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	89.9%	88.6%	89.0%	75th	88.4%
Annual Dental Visit for Children (2-18 Years)	-	41.1%	51.2%	25th	54.9%
Annual Dental Visit for Adults (19-64 Years)	-	45.1%	45.1%	No Benchmark	40.0%
Breast Cancer Screening (50-64 Years)[2]	76.1%	72.2%	74.6%	95th	64.9%
Cervical Cancer Screening (24-64 Years)[2]	58.5%	57.8%	51.8%	10th	54.7%
Children and Adolescents' Access to PCPs (12-24 Months)[2]	Small Sample	Small Sample	Small Sample	Not Applicable	96.9%
Children and Adolescents' Access to PCPs (25 Months-6 Years)[2]	Small Sample	Small Sample	Small Sample	Not Applicable	91.2%
Children and Adolescents' Access to PCPs (12-19 Years)[2]	Small Sample	98.3%	92.9%	75th	89.4%
Chlamydia Screening in Women (16-24 Years)[2]	42.0%	41.4%	37.2%	<10th	55.9%
Comprehensive Diabetes Care: Eye Exam (18-64 Years)[1]	80.6%	75.9%	79.1%	95th	74.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1]	89.2%	92.4%	96.2%	95th	96.9%
Controlling High Blood Pressure[1]	74.3%	75.5%	75.4%	95th	75.4%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life[2]	Small Sample	Small Sample	Small Sample	Not Applicable	64.2%

[1] Rate calculated by the MCO using the hybrid methodology.
[2] Rate calculated by DHS using the administrative methodology.
MY= measurement year; QC= NCQA 2020 Quality Compass MY 2019; BMI= body mass index; PCPs= primary care providers.
Note 1: The NCQA benchmark used for the Annual Dental Visit for Children represents an expanded age group (2-20 year olds).

Table 48: PrimeWest Health HEDIS Performance – Reporting Years 2018, 2019 and 2020 (Continued)

HEDIS Measures	PrimeWest Health 2018 HEDIS MY 2017	PrimeWest Health 2019 HEDIS MY 2018	PrimeWest Health 2020 HEDIS MY 2019	*QC 2020* National Medicaid Benchmark Met/Exceeded	Statewide Average MY 2019
MSHO					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)[2]	99.1%	98.8%	99.0%	95th	98.3%
Breast Cancer Screening (65-74 Years)[2]	64.5%	64.1%	62.4%	66.67th	64.6%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)[2]	94.4%	93.0%	96.4%	95th	92.2%
MSC+					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)[2]	97.6%	98.1%	98.6%	95th	88.1%
Breast Cancer Screening (65-74 Years)[2]	54.9%	56.8%	54.8%	25th	40.4%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)[2]	83.1%	83.0%	78.3%	<10th	65.8%
SNBC					
Adult BMI Assessment[1] *(SNP)*	97.9%	97.1%	94.1%	66.67th	94.1%
Adult BMI Assessment[1] *(Non-SNP)*	92.5%	92.5%	93.9%	66.67th	93.9%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	92.2%	92.9%	92.1%	95th	92.7%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	96.0%	95.6%	96.5%	95th	96.4%
Breast Cancer Screening (50-64 Years)[2]	58.0%	67.9%	70.4%	90th	53.3%
Cervical Cancer Screening (24-64 Years)[2]	45.2%	49.9%	39.5%	<10th	41.3%
Chlamydia Screening in Women (16-24 Years)[2]	Small Sample	Small Sample	20.6%	<10th	41.1%
Comprehensive Diabetes Care: Eye Exam (18-64 Years)[1] *(SNP)*	92.5%	97.9%	88.9%	95th	88.9%
Comprehensive Diabetes Care: Eye Exam (18-64 Years)[1] *(Non-SNP)*	64.4%	68.6%	76.9%	95th	76.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1] *(SNP)*	92.5%	95.7%	93.3%	90th	93.3%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Year)[1] *(Non-SNP)*	83.5%	89.3%	89.2%	50th	89.2%
Controlling High Blood Pressure[1] *(SNP)*	85.7%	80.4%	87.5%	95th	87.5%
Controlling High Blood Pressure[1] *(Non-SNP)*	71.3%	74.4%	74.3%	90th	74.3%

[1] Rate calculated by the MCO using the hybrid methodology.
[2] Rate calculated by DHS using the administrative methodology.
MY= measurement year; QC= NCQA 2020 Quality Compass MY 2019; SNP= special needs plan.

Figure 9: PrimeWest Health 2020 HEDIS Measure Matrix

2018 – 2019 Rate Change	Statewide Average Statistical Significance Comparison		
	Below Average	**Statewide Average**	**Above Average**
	C	**B**	**A** ▪ Annual Dental Visit (F&C-MA)
	D ▪ Chlamydia Screening in Women (F&C-MA, MNCare) ▪ Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (F&C-MA)	**C** ▪ Adult BMI Assessment (F&C-MA, MNCare) ▪ Annual Dental Visit-Children (MNCare) ▪ Adolescent Well-Care Visit (F&C-MA) ▪ Breast Cancer Screening (MSHO) ▪ Controlling High Blood Pressure (F&C-MA, MNCare, SNBC SNP, SNBC Non-SNP) ▪ Comprehensive Diabetes Care-Eye Exam (F&C-MA, MNCare, SNBC SNP, SNBC Non-SNP) ▪ Comprehensive Diabetes Care-HbA1c Testing (F&C-MA, MNCare, SNBC) ▪ Childhood Immunization Status (F&C-MA) ▪ Well-Child Visits in the First 15 Months of Life-6+ Visits ▪ (F&C-MA)	**B** ▪ Annual Dental Visit-Adult (F&C-MA, MNCare) ▪ Breast Cancer Screening (F&C-MA, MSC+, MNCare, SNBC)
	F ▪ Cervical Cancer Screening (F&C-MA)	**D** ▪ Adolescent Well-Care Visit (MNCare) ▪ Cervical Cancer Screening (MNCare, SNBC)	**C**

Key to the Measure Matrix

A	Notable performance. MCO may continue with internal goals.
B	MCOs may identify continued opportunities for improvement, but no required action.
C	MCOs should identify opportunities for improvement, but no immediate action required.
D	Conduct root cause analysis and develop action plan.
F	Conduct root cause analysis and develop action plan.

Table 49: PrimeWest Health CAHPS Performance – 2018, 2019 and 2020

CAHPS Measures	PrimeWest Health CAHPS 2018	PrimeWest Health CAHPS 2019	PrimeWest Health CAHPS 2020	*QC 2020* National Medicaid Benchmark Met/Exceeded	2020 Statewide Average
F&C-MA					
Getting Needed Care*	84.3%	82.1%	81.3%	25th	81.7%
Getting Care Quickly*	84.4%	84.2%	84.5%	50th	83.8%
How Well Doctors Communicate*	96.5%	94.7%	96.5%	95th	94.7%
Customer Service*	88.2%	95.2%	93.7%	95th	88.3%
Shared Decision Making*	79.1%	82.6%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	54.8%	57.5%	50.9%	<10th	52.5%
Rating of Personal Doctor**	69.7%	70.7%	65.8%▼	10th	71.6%
Rating of Specialist Seen Most Often**	64.2%	61.5%	66.1%	25th	63.7%
Rating of Health Plan**	59.5%	67.0%	57.3%	10th	56.8%
MNCare					
Getting Needed Care*	86.1%	86.3%	84.6%	50th	83.3%
Getting Care Quickly*	87.7%	86.2%	88.5%▲	95th	83.2%
How Well Doctors Communicate*	96.1%	95.8%	97.0%	95th	96.9%
Customer Service*	89.8%	82.7%	86.8%	10th	88.6%
Shared Decision Making*	83.9%	76.7%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	51.9%	50.5%	49.0%	<10th	52.2%
Rating of Personal Doctor**	69.2%	71.1%	70.1%	50th	71.5%
Rating of Specialist Seen Most Often**	65.6%	65.5%	58.7%	<10th	62.7%
Rating of Health Plan**	53.8%	56.1%	47.8%	<10th	50.9%

F&C-MA Response Rate = 26.38%. Sample Size = 1,350. Complete Surveys = 354.
MNCare Response Rate = 35.30%. Sample Size = 1,350. Complete Surveys = 467.
* Measure represents the percent of members who responded "yes," "usually" or "always."
** Ratings range from 0 to 10. This measure represents the percent of members who responded "9" or "10."
▲ Statistically significantly higher than the Total MCO program average.
▼ Statistically significantly lower than the Total MCO program average.

Table 49: PrimeWest Health CAHPS Performance – 2018, 2019 and 2020 (Continued)

CAHPS Measures	PrimeWest Health CAHPS 2018	PrimeWest Health CAHPS 2019	PrimeWest Health CAHPS 2020	*QC 2020* National Medicaid Benchmark Met/Exceeded	2020 Statewide Average
MSC+					
Getting Needed Care*	88.6%	89.5%	87.9%	75th	86.1%
Getting Care Quickly*	90.9%	88.9%	88.9%	95th	86.2%
How Well Doctors Communicate*	96.3%	95.4%	94.0%	50th	94.9%
Customer Service*	94.4%	92.3%	91.4%	75th	90.1%
Shared Decision Making*	78.1%	80.2%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	60.3%	60.7%	57.7%	50th	56.7%
Rating of Personal Doctor**	77.0%	73.7%	72.0%	66.67th	74.3%
Rating of Specialist Seen Most Often**	72.6%	68.7%	72.2%	50th	71.6%
Rating of Health Plan**	71.9%	64.0%	64.4%	50th	62.4%
SNBC					
Getting Needed Care*	88.3%	84.0%	83.3%	33.33rd	83.6%
Getting Care Quickly*	87.2%	84.5%	88.9%	95th	84.7%
How Well Doctors Communicate*	94.0%	91.0%	93.4%	50th	93.9%
Customer Service*	94.6%	89.6%	89.3%	33.33rd	89.5%
Shared Decision Making*	83.5%	82.2%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	60.4%	50.3%	49.0%▼	<10th	53.0%
Rating of Personal Doctor**	74.9%	68.6%	69.0%	33.33rd	72.3%
Rating of Specialist Seen Most Often**	68.8%	70.4%	66.3%	25th	66.9%
Rating of Health Plan**	68.3%	60.4%	55.7%	10th	58.3%

MSC+ Response Rate = 56.18%. Sample Size = 1,350. Complete Surveys = 664.
SNBC Response Rate = 42.98%. Sample Size = 1,350. Complete Surveys = 569.
* Measure represents the percent of members who responded "yes," "usually" or "always."
** Ratings range from 0 to 10. This measure represents the percent of members who responded "9" or "10."
▼ Statistically significantly lower than the Total MCO program average.

PRIMEWEST HEALTH FINDINGS AND RECOMMENDATIONS

Strengths

- **NCQA Accreditation Survey –** PrimeWest Health maintained NCQA accreditation for the F&C-MA and MNCare programs.
- **Compliance –** PrimeWest Health was fully compliant with the standards of *Title 42 CFR Part 438 Managed Care Subpart D* and *Title 42 CFR § 438.330*.
- **PIP –** PrimeWest Health designed and conducted a PIP that met the standards of *Title 42 CFR 438.330(d)* and *Section 7.2* of the DHS model contract for MCOs.
- **ISCA –** PrimeWest Health met all IS requirements of the HEDIS Compliance Audit and successfully reported HEDIS data.
- **Member Satisfaction (CAHPS) –** PrimeWest Health achieved a significantly higher score than the statewide average for the following program and measure:
    - MNCare: Getting Care Quickly

Opportunities for Improvement

- **Compliance –**
    - **QAE:** PrimeWest Health received four (4) mandatory improvements for compliance with state standards.
    - **TCA:** PrimeWest Health received four (4) "not met" designations for compliance with state requirements.
- **Financial Withhold** – PrimeWest Health did not earn full points for the F&C-MA, MNCare, MSHO, MSC+ and SNBC programs. The MCO did not meet the target goal for the following measures:
    - F&C-MA and MNCare
        - Annual Dental Visit for Children (aged 1-20 years)
        - Annual Dental Visit for Adults (aged 21-64 years)
        - Provider Network Equity: FFS vs. MCO
        - Hospital 30-Day Readmission Rate
    - MSHO and MSC+
        - Annual Dental Visit Rate (aged 18-64 years)
    - SNBC
        - Annual Dental Visit Rate (aged 18-64 years)
- **Member Satisfaction (CAHPS) –** PrimeWest Health achieved a significantly lower score than the statewide average for the following program and measures:
    - F&C-MA: Rating of Personal Doctor
    - SNBC: Rating of All Health Care
- **Quality of Care (HEDIS) –** PrimeWest Health demonstrates an opportunity for improvement in the following areas:

- F&C-MA:
  - Chlamydia Screening in Women
  - Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life
  - Cervical Cancer Screening
- MNCare:
  - Chlamydia Screening in Women
  - Adolescent Well-care Visit
  - Cervical cancer screening
- SNBC:
  - Cervical Cancer Screening

Recommendations

- **Financial Withhold –**
  - PrimeWest Health should seek clarification from DHS regarding the dental measure specifications to determine if the PrimeWest Health withhold rates truly reflect the level of service provided. PrimeWest Health should continue its quality improvement strategy outlined for future years.
  - As medication errors were identified as a key driver of hospital readmissions, PrimeWest Health should consider collaborating with in-network pharmacists to support its medication reconciliation program.
- **Member Satisfaction (CAHPS) –** As HSAG identified, SNBC members not receiving care as quickly as they needed it as a key driver for the SNBC 'Rating of All Health Care' score, PrimeWest Health should focus on improving access to care and appointment availability. PrimeWest Health should identify the causes for the recent decline in member satisfaction with Rating of Personal Doctor in the F&C-MA program.
- **Quality of Care (HEDIS) –** PrimeWest Health should continue to identify innovative approaches, like at-home test kits, to improve areas of women's health and child/adolescent health. PrimeWest Health should consider increasing the frequency of its evaluation of network adequacy to identify access and appointment issues preventing members from accessing needed care. PrimeWest Health should continue to supply its provider network with clinical practice guidelines for appropriate care.

SOUTH COUNTRY HEALTH ALLIANCE (SOUTH COUNTRY)

CORPORATE PROFILE

South Country Health Alliance (South Country) is a partnership of eleven (11) Minnesota counties formed in 2001 as a CBP. South Country participates in the F&C-MA, MNCare, MSC+, MSHO and SNBC programs. As of December 2019, enrollment totaled 37,839, accounting for 4.1% of the entire MHCP population. **Table 50** displays South Country's enrollment as of December 2019.

Table 50: South Country Enrollment as of December 2019

Program	Enrollment (as of December 2019)
F&C-MA	29,327
MNCare	3,072
MSC+	851
MSHO	1,754
SNBC	2,835
Total Enrollment	**37,839**

Source: Minnesota Health Care Enrollment Totals December 2019 Report.

QUALITY ASSURANCE EXAMINATION AND TRIENNIAL COMPLIANCE ASSESSMENT

MDH conducted the most recent QAE and TCA on May 20 through May 24, 2019. The examination period covered June 1, 2016 to February 28, 2019, while the file review period covered March 1, 2018 to February 28, 2019. The MCO received total of one (1) recommendation, four (4) mandatory improvements, and four (4) deficiencies for the QAE. The MCO received four (4) "not met" designations for the TCA. However, the results of the TCA also concluded that South Country was compliant with the standards described in 42 CFR 438 Subpart D. **Table 51** presents a summary of these findings.

Table 51: South Country Compliance Review Results for Part 438 Subpart D and QAPI Standards

42 CFR 438 Subpart D and Quality Assessment and Performance Improvement Program Standards	Review Determination (Met or Not Met)
Access Standards 438.206 Availability of Services 438.207 Assurances of Adequate Capacity and Services 438.208 Coordination and Continuity of Care 438.210 Coverage and Authorization of Service	Met
Structure and Operations Standards 438.214 Provider Selection 438.224 Confidentiality and Accuracy of Enrollee Records 438.228 Grievance Systems 438.230 Sub Contractual Relationships and Delegation	Met
Measurement Improvement Standards 438.236 Practice Guidelines Program 438.242 Health Information System	Met
Written Quality Assurance Plan (Quality Program Description) 438.330 Quality Assessment and Performance Improvement Program	Met

CFR= Code of Federal Regulations

PERFORMANCE IMPROVEMENT PROJECTS

DHS's validation of South Country's 2019 PIP confirmed its compliance with the standards of *Title 42 CFR 438.330(d)* and *Section 7.2 of* the DHS model contract for MCOs.

South Country made alignment of pharmacy practices a priority. Changes to the pharmacy formulary were made to align with the Universal Pharmacy Policy Workgroup and the Opioid Prescribing Improvement Program guidelines. South Country utilized opioid-specific case management as a cornerstone of their PIP interventions. As a part of this approach, South Country is encouraging the use of shared-decision making between members and providers to make the most informed and advantageous care decisions regarding pain management. This included member education regarding the effectiveness (or lack thereof) of opioids for treating chronic pain and non-opioid treatment options as alternatives. The use of case management and opioid alternatives were tracked throughout the duration of the PIP.

Table 52 presents 2017-2019 new chronic user rates for South Country and the state. As this is the first reporting cycle looking back on the first year of the PIP, there is not sufficient information to draw specific conclusions.

Table 52: South Country PIP Rates – New Chronic Users

Reporting Year	South Country Rate	Statewide Average Rate
F&C-MA and MNCare		
2017 (baseline)	3.3%	3.5%
2018 (intervention year 1)	2.5%	2.7%
2019 (intervention year 2)	2.1%	2.1%
MSHO and MSC+		
2017 (baseline)	22.1%	18.5%
2018 (intervention year 1)	21.0%	22.9%
2019 (intervention year 2)	14.9%	14.9%
SNBC		
2017 (baseline)	12.5%	9.9%
2018 (intervention year 1)	6.7%	8.84%
2019 (intervention year 2)	4.2%%	7.5%

PIP= performance improvement project.

Table 53 displays validations results for the South Country PIP.

Table 53: South Country PIP Validation Results

PIP Validation Elements	Validation Results
Selected Topic	Met
Study Question	Met
Indicators	Met
Population	Met
Sampling Methods	Met
Data Collection Procedures	Met
Interpretation of Study Results	Met
Improvement Strategies	Met

PIP= performance improvement project.

2019 Financial Withhold

South Country achieved 4.40 points (of 100 points) for the F&C-MA and MNCare programs, 85.96 points (of 90 points) for the MSHO and MSC+ programs and 60 points (of 60 points) for the SNBC program. **Table 54** displays the results of the 2019 Financial Withhold, including performance measures, point values, and points earned by South Country.

Table 54: South Country 2019 Financial Withhold

Performance Measure	Point Value	Points Earned
F&C-MA and MNCare		
Annual Dental Visit: Age stratification 1-20 years	55	0
Annual Dental Visit: Age stratification 21-64 years	30	0
Provider Network Equity: FFS vs. MCO	10	0
Repeat Deficiencies on the MDH QAE	2	2
Emergency Department (ED) Utilization Rate	1	1
Hospital Admission Rate	1	0.4
Hospital 30-Day Readmission Rate	1	1
TOTAL	**100**	**4.40**
MSHO and MSC+		
Repeat Deficiencies on the MDH QAE	15	15
Care Plan Audit	15	15
Initial Health Risk Screening/Assessment	30	30
Stakeholder Group Reporting	15	15
Annual Dental Visit: Age 65+	15	10.96
TOTAL	**90**	**85.96**
SNBC		
Repeat Deficiencies on the MDH QAE	15	15
Compliance with Service Accessibility Requirements	15	15
Stakeholder Group Reporting	15	15
Annual Dental Visit: Age 18-64	15	15
TOTAL	**60**	**60**

Annual Quality Assurance Work Plan for 2019

South Country developed a quality assurance work plan compliant with Minnesota Administrative Rule 4685.1130. The work plan categorizes quality-related activities by topic, such as delegation oversight, compliance, care coordination, and populations with special needs. The following information is provided for each activity included within the work plan: objectives, actions planned, resources, responsible staff, timeline, and project status.

Evaluation of the 2019 Annual Quality Assessment and Performance Improvement Program

Through the activities of the Quality Program, South Country strives to: establish effective partnerships with healthcare stakeholders establish and measure performance expectations, improve health outcomes of members through nine (9) domains of care, improve and clarify member satisfaction, ensure appropriate access and meet regulatory requirements. Quality management documents completed in the year 2019 include the 2019 Quality Work Plan, the 2019 Quality Program Description, and the 2018 Annual Quality Program Evaluation. Auditing and monitoring is performed through the Delegation and Oversight Program, the Internal Audit and Monitoring Program, the MDH Quality

Assurance Exam and the Triennial Compliance Audit. In 2019, the South Country has demonstrated the progress of programs to meet and exceed network wide safe clinical practices; the primary example being the effectiveness of their Opioid Case Management program. Highlights from 2019 include earning a 4.5 Star Quality Rating from CMS on their SeniorCare Complete product for 2020, successful HEDIS submissions, their Opioid Case Management program, improving dental access, member satisfaction rates and the implementation of utilization management for medical services.

MCO Clinical Practice Guidelines

South Country recognizes the following sources for clinical practice guidelines:

- USPSTF
  - Preventive services for adults
  - Preventative services for children and adolescents
- AAFP
  - Prenatal Care
- ICSI
  - Diabetes, Type 2
  - Asthma
  - Hypertension diagnosis and treatment
  - Depression in adults
- AACAP
  - Children and adolescents with attention-deficit hyperactivity disorder

Quality Improvement Program Website[42]

South Country's quality improvement program website presents the MCO's goals and access to quality-related documents including the MCO's Quality Program Description and PIP reports. The framework of South Country's quality program guides the formal process for evaluating and improving the quality and appropriateness of health services and the health status of its members.

Performance Measures

Information Systems Capabilities Assessment

The 2020 HEDIS FAR for MY 2019 produced by Attest Health Care Advisors indicated that South Country met all of the requirements to successfully report HEDIS data to DHS. **Table 55** displays the results of the IS audit.

[42] South Country Quality Improvement Program Website: https://mnscha.org/?page_id=5924

Table 55: South Country Compliance with Information System Standards

Information System Standard	Review Result
1.0 Medical Services Data	Met
2.0 Enrollment Data	Met
3.0 Practitioner Data	Met
4.0 Medical Record Review Processes	Met
5.0 Supplemental Data	Met
6.0 Data Preproduction Processing	Met
7.0 Data Integration and Reporting	Met

HEDIS – Quality, Timeliness and Access

Due to the coronavirus disease of 2019 (COVID-19) outbreak and in accord with NCQA recommendations, DHS and MDH allowed Medicaid MCOs to request a waiver to report audited HEDIS MY 2018 hybrid rates if they were not able to complete HEDIS MY 2019 hybrid medical record chart reviews according to NCQA technical specifications.

South Country's waiver to report HEDIS MY 2018 hybrid rates for HEDIS MY 2019 was approved. All HEDIS rates in **Table 56** were administratively calculated by DHS.

South Country HEDIS rates are displayed in **Table 56**. The results of the MCO's Measure Matrix analysis are presented in **Figure 10**.

Table 56: South Country HEDIS Performance – Reporting Years 2018, 2019 and 2020

HEDIS Measures	South Country 2018 HEDIS MY 2017	South Country 2019 HEDIS MY 2018	South Country 2020 HEDIS MY 2019	*QC 2020* National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
F&C-MA					
Adolescent Well-Care Visit (12-21 Years)	38.5%	36.6%	36.7%	<10th	42.6%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)	84.7%	83.5%	83.2%	75th	82.8%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)	85.9%	86.7%	85.9%	33.33rd	86.8%
Annual Dental Visit for Children (2-18 Years)	-	54.8%	58.2%	33.33rd	57.4%
Annual Dental Visit for Adults (19-64 Years)	-	35.5%	37.4%	No Benchmark	37.4%
Breast Cancer Screening (50-64 Years)	68.5%	62.2%	61.3%	66.67th	59.8%
Cervical Cancer Screening (24-64 Years)	60.1%	56.6%	52.3%	10th	56.3%
Childhood Immunization Status: Combo 3 (2 Years)	77.5%	67.3%	66.5%	10th	53.0%
Children and Adolescents' Access to PCPs (12-24 Months)	97.2%	97.6%	96.3%	50th	96.3%
Children and Adolescents' Access to PCPs (25 Months-6 Years)	89.5%	87.3%	88.8%	50th	88.5%
Children and Adolescents' Access to PCPs (7-11 Years)	92.5%	91.1%	90.3%	33.33rd	91.7%
Children and Adolescents' Access to PCPs (12-19 Years)	93.6%	92.2%	91.2%	50th	91.9%
Chlamydia Screening in Women (16-24 Years)	46.1%	48.3%	39.7%	<10th	55.1%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)	88.8%	89.5%	90.2%	50th	84.0%
Well-Child Visits in the First 15 Months of Life (6+ Visits)	64.7%	67.4%	61.0%	10th	64.2%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	62.1%	61.5%	60.4%	<10th	65.9%

MY= measurement year; QC= NCQA 2020 Quality Compass MY 2019; PCPs= primary care providers.
All rates were calculated by DHS using the administrative methodology.
Note 1: HEDIS hybrid rates are not reported by the MCO because of NCQA reporting changes due to COVID-19. See note on pg. 19. HEDIS Hybrid measures include Adult BMI Assessment, Comprehensive Diabetes Care: Eye Exam.
Note 2: The measure 'Medication Management for People With Asthma (5-64 years)' is no longer included in this report.
Note 3: The NCQA benchmark used for the Annual Dental Visit for Children represents an expanded age group (2-20 year olds).

Table 56: South Country HEDIS Performance – Reporting Years 2018, 2019 and 2020 (Continued)

HEDIS Measures	South Country 2018 HEDIS MY 2017	South Country 2019 HEDIS MY 2018	South Country 2020 HEDIS MY 2019	*QC 2020* National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
MNCare					
Adolescent Well-Care Visit (12-21 Years)	27.8%	25.9%	21.1%	<10th	25.4%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)	81.9%	81.1%	81.9%	66.67th	82.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)	87.9%	86.6%	88.1%	50th	88.4%
Annual Dental Visit for Children (2-18 Years)	-	42.9%	51.6%	25th	54.9%
Annual Dental Visit for Adults (19-64 Years)	-	35.1%	37.6%	No Benchmark	40.0%
Breast Cancer Screening (50-64 Years)	71.4%	70.3%	63.5%	66.67th	64.9%
Cervical Cancer Screening (24-64 Years)	54.1%	54.6%	48.4%	10th	54.7%
Children and Adolescents' Access to PCPs (12-24 Months)	Small Sample	Small Sample	Small Sample	Not Applicable	96.9%
Children and Adolescents' Access to PCPs (25 Months-6 Years)	Small Sample	Small Sample	Small Sample	Not Applicable	91.2%
Children and Adolescents' Access to PCPs (12-19 Years)	Small Sample	88.9%	93.9%	75th	89.4%
Chlamydia Screening in Women (16-24 Years)	50.0%	44.8%	41.3%	<10th	55.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)	97.1%	93.6%	91.1%	75th	89.0%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	Small Sample	Small Sample	Small Sample	Not Applicable	71.5%

MY= measurement year; QC= NCQA 2020 Quality Compass MY 2019; PCPs= primary care providers.
All rates were calculated by DHS using the administrative methodology.
Note 1: HEDIS hybrid rates are not reported by the MCO because of NCQA reporting changes due to COVID-19. See note on pg. 19. HEDIS Hybrid measures include Adult BMI Assessment, Comprehensive Diabetes Care: Eye Exam.
Note 2: The measure 'Medication Management for People With Asthma (5-64 years)' is no longer included in this report.
Note 3: The NCQA benchmark used for the Annual Dental Visit for Children represents an expanded age group (2-20 year olds).

Table 56: South Country HEDIS Performance – Reporting Years 2018, 2019 and 2020 (Continued)

HEDIS Measures	South Country 2018 HEDIS MY 2017	South Country 2019 HEDIS MY 2018	South Country 2020 HEDIS MY 2019	*QC 2020* National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
MSHO					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)	97.9%	98.4%	98.4%	95th	98.3%
Breast Cancer Screening (65-74 Years)	70.6%	71.9%	69.9%	90th	64.6%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)	96.4%	96.6%	91.7%	75th	92.2%
MSC+					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)	94.8%	93.7%	94.2%	75th	88.1%
Breast Cancer Screening (65-74 Years)	52.6%	57.7%	55.7%	33.33rd	40.4%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)	85.8%	92.5%	91.2%	75th	65.8%
SNBC					
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)	93.0%	94.3%	93.0%	95th	92.7%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)	97.6%	97.7%	96.6%	95th	96.4%
Breast Cancer Screening (50-64 Years)	70.0%	69.8%	70.9%	90th	53.3%
Cervical Cancer Screening (24-64 Years)	50.5%	52.1%	41.4%	<10th	41.3%
Chlamydia Screening in Women (16-24 Years)	Small Sample	Small Sample	Small Sample	Not Applicable	41.1%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)	91.3%	90.5%	90.1%	50th	80.6%

MY= measurement year; QC= NCQA 2020 Quality Compass MY 2019; PCPs= primary care providers.
All rates were calculated by DHS using the administrative methodology.
Note 1: HEDIS hybrid rates are not reported by the MCO because of NCQA reporting changes due to COVID-19. See note on pg. 19. HEDIS Hybrid measures include Adult BMI Assessment, Comprehensive Diabetes Care: Eye Exam.
Note 2: The measure 'Medication Management for People With Asthma (5-64 years)' is no longer included in this report.

Figure 10: South Country 2020 HEDIS Measure Matrix

2018 – 2019 Rate Change	Statewide Average Statistical Significance Comparison		
	Below Average	**Statewide Average**	**Above Average**
	C	**B** ▪ Annual Dental Visit-Adult (F&C-MA) ▪ Annual Dental Visit-Children (F&C-MA)	**A**
	D ▪ Annual Dental Visit-Adult (MNCare) ▪ Adolescent Well-Care Visit (F&C-MA) ▪ Chlamydia Screening in Women (MNCare) ▪ Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (F&C-MA)	**C** ▪ Annual Dental Visit-Children (MNCare) ▪ Adolescent Well-Care Visit (MNCare) ▪ Breast Cancer Screening (F&C-MA, MSHO, MNCare) ▪ Comprehensive Diabetes Care-HbA1c Testing (MNCare)	**B** ▪ Breast Cancer Screening (MSC+, SNBC) ▪ Comprehensive Diabetes Care-HbA1c Testing (F&C-MA, MSC+, SNBC) ▪ Childhood Immunization Status (F&C-MA)
	F ▪ Cervical Cancer Screening (F&C-MA, MNCare) ▪ Chlamydia Screening in Women (F&C-MA)	**D** ▪ Cervical Cancer Screening (SNBC) ▪ Comprehensive Diabetes Care-HbA1c Testing (MSHO) ▪ Well-Child Visits in the First 15 Months of Life-6+ Visits (F&C-MA)	**C**

Key to the Measure Matrix

A Notable performance. MCO may continue with internal goals.
B MCOs may identify continued opportunities for improvement, but no required action.
C MCOs should identify opportunities for improvement, but no immediate action required.
D Conduct root cause analysis and develop action plan.
F Conduct root cause analysis and develop action plan.

Table 57: South Country CAHPS Performance – 2018, 2019 and 2020

CAHPS Measures	South Country CAHPS 2018	South Country CAHPS 2019	South Country CAHPS 2020	*QC 2020* National Medicaid Benchmark Met/Exceeded	2020 Statewide Average
F&C-MA					
Getting Needed Care*	86.6%	92.2%	81.6%	33.33rd	81.7%
Getting Care Quickly*	86.4%	88.7%	85.4%	66.67th	83.8%
How Well Doctors Communicate*	97.9%	98.0%	93.1%	33.33rd	94.7%
Customer Service*	92.2%	92.2%	87.4%	10th	88.3%
Shared Decision Making*	86.1%	85.7%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	53.8%	55.4%	53.5%	10th	52.5%
Rating of Personal Doctor**	68.6%	73.8%	76.0%	90th	71.6%
Rating of Specialist Seen Most Often**	68.2%	65.0%	64.9%	10th	63.7%
Rating of Health Plan**	62.0%	60.6%	56.7%	10th	56.8%
MNCare					
Getting Needed Care*	86.1%	86.3%	84.6%	50th	83.3%
Getting Care Quickly*	87.7%	86.2%	88.5%▲	95th	83.2%
How Well Doctors Communicate*	96.1%	95.8%	97.0%	95th	96.9%
Customer Service*	89.8%	82.7%	86.8%	10th	88.6%
Shared Decision Making*	83.9%	76.7%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	51.9%	50.5%	49.0%	<10th	52.2%
Rating of Personal Doctor**	69.2%	71.1%	70.1%	50th	71.5%
Rating of Specialist Seen Most Often**	65.6%	65.5%	58.7%	<10th	62.7%
Rating of Health Plan**	53.8%	56.1%	47.8%	<10th	50.9%

F&C-MA Response Rate = 26.11%. Sample Size = 1,350. Complete Surveys = 347.
MNCare Response Rate = 35.50%. Sample Size = 1,350. Complete Surveys = 467.
* Measure represents the percent of members who responded "yes," "usually" or "always."
** Ratings range from 0 to 10. This measure represents the percent of members who responded "9" or "10."
▲ Statistically significantly higher than the Total MCO program average.

Table 57: South Country CAHPS Performance – 2018, 2019 and 2020 (Continued)

CAHPS Measures	South Country CAHPS 2018	South Country CAHPS 2019	South Country CAHPS 2020	*QC 2020* National Medicaid Benchmark Met/Exceeded	2020 Statewide Average
MSC+					
Getting Needed Care*	88.6%	89.5%	87.9%	75th	86.1%
Getting Care Quickly*	90.9%	88.9%	87.7%	90th	86.2%
How Well Doctors Communicate*	96.3%	95.4%	94.0%	50th	94.9%
Customer Service*	94.4%	92.3%	91.4%	66.67th	90.1%
Shared Decision Making*	78.1%	80.2%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	60.3%	60.7%	57.7%	50th	56.7%
Rating of Personal Doctor**	77.0%	73.7%	72.0%	66.67th	74.3%
Rating of Specialist Seen Most Often**	72.6%	68.7%	72.2%	50th	71.6%
Rating of Health Plan**	71.9%	64.0%	64.4%	50th	62.4%
SNBC					
Getting Needed Care*	88.3%	84.0%	83.3%	33.33rd	83.6%
Getting Care Quickly*	87.2%	84.5%	84.9%	66.67th	84.7%
How Well Doctors Communicate*	94.0%	91.0%	93.4%	50th	93.9%
Customer Service*	94.6%	89.6%	89.3%	33.33rd	89.5%
Shared Decision Making*	83.5%	82.2%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	60.4%	50.3%	49.0%▼	<10th	53.0%
Rating of Personal Doctor**	74.9%	68.6%	69.0%	33.33rd	72.3%
Rating of Specialist Seen Most Often**	68.8%	70.4%	66.3%	25th	66.9%
Rating of Health Plan**	68.3%	60.4%	55.7%	10th	58.3%

MSC+ Response Rate = 56.18%. Sample Size = 1,224. Complete Surveys = 664.
SNBC Response Rate = 42.98%. Sample Size = 1,350. Complete Surveys = 569.
* Measure represents the percent of members who responded "yes," "usually" or "always."
** Ratings range from 0 to 10. This measure represents the percent of members who responded "9" or "10."
▼ Statistically significantly lower than the Total MCO program average.

SOUTH COUNTRY FINDINGS AND RECOMMENDATIONS

Strengths

- **Compliance –** South Country was fully compliant with the standards of *Title 42 CFR Part 438 Managed Care Subpart D* and *Title 42 CFR § 438.330*.
- **PIP** – **South Country** designed and conducted a PIP that met the standards of *Title 42 CFR 438.330(d)* and *Section 7.2* of the DHS model contract for MCOs.
- **Financial Withhold** – South Country achieved fully points for the SNBC program.
- **ISCA** – **South Country** met all IS requirements of the HEDIS Compliance Audit and successfully reported HEDIS data.
- **Member Satisfaction (CAHPS) –** South Country achieved a significantly higher score than the statewide average for the following program and measure:
    - MNCare: Getting Care Quickly

Opportunities for Improvement

- **Compliance –**
    - **QAE:** South Country received one (1) recommendation, four (4) mandatory improvements, and four (4) deficiencies for compliance with state standards.
    - **TCA:** South Country received four (4) "not met" designations for compliance with state requirements.
- **Financial Withhold** – South Country did not earn full points for the F&C-MA, MNCare, MSHO, and MSC+ programs. The MCO did not meet the target goal for the following measures:
    - F&C-MA and MNCare
        - Annual Dental Visit for Children (aged 1-20 years)
        - Annual Dental Visit for Adults (aged 21-64 years)
        - Provider Network Equity: FFS vs. MCO
        - Hospital 30-Day Readmission Rate
    - MSHO and MSC+
        - Annual Dental Visit Rate (aged 18-64 years)
- **Member Satisfaction (CAHPS) –** South Country achieved a significantly lower score than the statewide average for the following program and measures:
    - SNBC: Rating of All Health Care
- **Quality of Care (HEDIS) –** South Country demonstrates an opportunity for improvement in the following areas:
    - F&C-MA:
        - Chlamydia Screening in Women
        - Cervical Cancer Screening
        - Well-Child Visits in the First 15 Months of Life-6+ Visits

        - Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
        - Adolescent Well-Care Visits
    - MNCare:
        - Chlamydia Screening in Women
        - Cervical Cancer Screening
    - SNBC
        - Cervical Cancer Screening

Recommendations

- **Financial Withhold** –
    - Although dental care remains an issue, South Country should continue its quality improvement strategy described in the South Country response to the previous year's recommendation. South Country should also consider collaborating with the other MCOs to develop a broader plan for addressing the shortage of dental providers across the state.
    - Concerning hospital readmissions, to prevent hospital readmissions South Country should consider enhancing its member identification strategy to include prospective analysis.
- **Member Satisfaction (CAHPS) –** As HSAG identified, SNBC members not receiving care as quickly as they needed it as a key driver for the SNBC 'Rating of All Health Care' score, South Country should focus on improving access to care and appointment availability.
- **Quality of Care (HEDIS) –** As specific areas of in women's health and child/adolescent care continue to need improvement, South Country should consider partnering with community based organizations to promote the importance of preventive care.

UCARE

CORPORATE PROFILE

UCare is an independent, non-profit MCO founded in 1984 by the Department of Family Practice at the University of Minnesota Medical School. UCare serves enrollees in the F&C-MA, MNCare, MSC+, MSHO and SNBC programs. As of December 2019, enrollment totaled 291,383, accounting for 31.7% of the entire MHCP population. **Table 58** displays UCare's enrollment as of December 2019.

Table 58: UCare Enrollment as of December 2019

Program	Enrollment (as of December 2019)
F&C-MA	218,609
MNCare	25,875
MSC+	5,490
MSHO	12,721
SNBC	28,688
Total Enrollment	**291,383**

Source: Minnesota Health Care Enrollment Totals December 2019 Report.

QUALITY ASSURANCE EXAMINATION AND TRIENNIAL COMPLIANCE ASSESSMENT

MDH conducted the most recent QAE and TCA on May 7, 2018 through May 11, 2018. The examination period covered December 1, 2015 to February 28, 2018. During this cycle, there were two file review periods: November 1, 2017 to March 1, 2018 and December 1, 2017 to March 1, 2018. The MCO received a total of one (1) recommendation and five (5) deficiencies on the QAE. The MCO was fully compliant with contract elements reviewed for the TCA. A mid-cycle review of the corrective action plan submitted by UCare stated that all five (5) deficiencies were addressed. However, UCare was required to submit a corrective action plan related to pharmaceutical notification of denial and appeal rights.

The results of the TCA also concluded that South Country was compliant with the standards described in 42 CFR 438 Subpart D. **Table 59** presents a summary of these findings.

Table 59: UCare Compliance Review Results for Part 438 Subpart D and QAPI Standards

42 CFR 438 Subpart D and Quality Assessment and Performance Improvement Program Standards	Review Determination (Met or Not Met)
Access Standards 438.206 Availability of Services 438.207 Assurances of Adequate Capacity and Services 438.208 Coordination and Continuity of Care 438.210 Coverage and Authorization of Service	Met
Structure and Operations Standards 438.214 Provider Selection 438.224 Confidentiality and Accuracy of Enrollee Records 438.228 Grievance Systems 438.230 Sub Contractual Relationships and Delegation	Met
Measurement Improvement Standards 438.236 Practice Guidelines Program 438.242 Health Information System	Met
Written Quality Assurance Plan (Quality Program Description) 438.330 Quality Assessment and Performance Improvement Program	Met

CFR= Code of Federal regulations.

PERFORMANCE IMPROVEMENT PROJECTS

DHS's validation of UCare's 2019 PIP confirmed its compliance with the standards of *Title 42 CFR 438.330(d)* and *Section 7.2 of* the DHS model contract for MCOs.

UCare emphasized safe disposal of opioids, member education and communication, opioid prescribing management, and supporting opioid alternatives in unique ways for their population, as other plans have done. UCare also engaged in provider monitoring; providers who demonstrate high rates of opioid prescribing or who regularly prescribe high amounts of opioids were contacted and educated on statewide and national prescribing guidelines. This was an attempt to bring the provider community into alignment with prescribing practices. Additionally, UCare funded grants for the Hennepin Health Foundation emergency room opioid use detoxification initiative for UCare members seen at Hennepin County Medical Center. This initiative supported the emergency room environment as a point of first contact with patients wherein treatment for Opioid Use Disorder can begin.

Table 60 presents 2017-2019 new chronic user rates for UCare and the state. As this is the first reporting cycle looking back on the first year of the PIP, there is not sufficient information to draw specific conclusions.

Table 60: UCare PIP Rates – New Chronic Users

Reporting Year	UCare Rate	Statewide Average Rate
F&C-MA and MNCare		
2017 (baseline)	3.8%	3.5%
2018 (intervention year 1)	3.0%	2.7%
2019 (intervention year 2)	2.2%	2.1%
MSHO and MSC+		
2017 (baseline)	16.6%	18.5%
2018 (intervention year 1)	16.9%	22.9%
2019 (intervention year 2)	13.0%	14.9%
SNBC		
2017 (baseline)	11.4%	9.9%
2018 (intervention year 1)	10.3%	8.84%
2019 (intervention year 2)	7.4%	7.5%

PIP= performance improvement project.

Table 61 displays validations results for the UCare PIP.

Table 61: UCare PIP Validation Results

PIP Validation Elements	Validation Results
Selected Topic	Met
Study Question	Met
Indicators	Met
Population	Met
Sampling Methods	Met
Data Collection Procedures	Met
Interpretation of Study Results	Met
Improvement Strategies	Met

PIP= performance improvement project.

2019 Financial Withhold

UCare achieved 3.02 points (of 100 points) for the F&C-MA and MNCare programs, 82.02 points (of 90 points) for the MSHO and MSC+ programs and 53.72 points (of 60 points) for the SNBC program. **Table 62** displays the results of the 2019 Financial Withhold, including performance measures, point values, and points earned by UCare.

Table 62: UCare 2019 Financial Withhold

Performance Measure	Point Value	Points Earned
F&C-MA and MNCare		
Annual Dental Visit: Age stratification 1-20 years	55	0
Annual Dental Visit: Age stratification 21-64 years	30	0
Provider Network Equity: FFS vs. MCO	10	0
Repeat Deficiencies on the MDH QAE	2	2
Emergency Department (ED) Utilization Rate	1	0.02
Hospital Admission Rate	1	1
Hospital 30-Day Readmission Rate	1	0
TOTAL	**100**	**3.02**
MSHO and MSC+		
Repeat Deficiencies on the MDH QAE	15	15
Care Plan Audit	15	15
Initial Health Risk Screening/Assessment	30	30
Stakeholder Group Reporting	15	15
Annual Dental Visit: Age 65+	15	7.02
TOTAL	**90**	**82.02**
SNBC		
Compliance with Service Accessibility Requirements	15	15
Stakeholder Group Reporting	15	15
Annual Dental Visit: Age 18-64	15	8.72
TOTAL	**60**	**53.72**

ANNUAL QUALITY ASSURANCE WORK PLAN FOR 2019

UCare developed a quality assurance work plan compliant with Minnesota Administrative Rule 4685.1130. UCare has implemented activities addressing network appointment availability, quality and safety issues, auditing, data validation, file review criteria, UM program structure, member satisfaction outreach to members and the fifteen (15) Culturally and Linguistically Appropriate Services (CLAS) standards. These were just some of the activities implemented in order to address previously identified issues in 2018. Products used include EssentiaCare, MinnesotaCare, Minnesota Senior Care Plus, Minnesota Senior Health Options, Families and Children Prepaid Medical Assistance Plans, UCare Connect, UCare Connect + Medicare and UCare Medicare Plans, UCare Medicare with Fairview and North Memorial. The objectives highlighted in the 2019 Quality Program Work Plan to improve quality overall included: monitoring clinical, operational, and satisfaction initiatives; reviewing program structure and UM written criteria; meeting access standards; monitoring practitioner sanctions, complaints, and quality issues; monitoring access to healthcare services, identifying opportunities to improve data accuracy and ensuring that guidelines are adopted.

Evaluation of the 2019 Annual Quality Assessment and Performance Improvement Program

The goals of UCare's Quality Program were to: maintain NCQA accreditation, improve Star Ratings and Medicaid measures, coordinate quality improvement activities, improve health care services across the continuum of care, address social factors and health disparities, implement a population health strategy, promote patient safety, foster partnerships with stakeholders, improve member outcomes, maintain compliance with regulatory requirements, adhere to accreditation and UCare standards and promote diversity for members and providers. Overall, most activities planned in the 2019 work plan were achieved. While HEDIS results for the measures adult BMI, breast cancer screening, colorectal cancer screening, comprehensive diabetes care and controlling high blood pressure measures had increased in 2019, the high-risk medications, medication therapy management (MTM) and generic medication fill rates measures displayed opportunities for improvement. Regarding member experience, the UCare Medicare results are at or above the CAHPS national average in almost all areas. MSHO scores for 36 measures are comparable to the national average, with no measures significantly below average. UCare also administered the CMS CAHPS survey where seven of eight measures improved from 2018 to 2019. The QHP survey showed a decrease in performance from 2018 to 2019, as all measures dropped below national average and require assessment and evaluation. While the experience of care and health outcomes survey requires improvement with multiple measures falling below the UCare benchmark, the 2019 new member survey results indicate that the information and resources UCare provides to newly enrolled members is understood overall. UCare mainly monitored the accessibility of care, network transparency and the accuracy of health information. Member safety was also assessed based on the quality of care, safety initiatives, wellness initiatives and medication adherence. Focus studies were mainly based on opioid use, cervical cancer screenings, continuity of care and dental services.

MCO Clinical Practice Guidelines

UCare recognizes the following sources for clinical practice guidelines:

- Global Initiative for Asthma
  - Diagnosis and management of asthma
- ADA
  - Diagnosis and management of type 2 diabetes
- JACC
  - Management of heart failure in adults
- AAFP
  - Prevention and management of obesity in adults
  - Prenatal care
  - Preventive services for adults
- AAP
  - Preventive services for children and adolescents

- AACAP
  - Assessment and treatment of children with attention-deficit hyperactivity disorder
  - Assessment and treatment of children and adolescents with depressive disorders
- APA
  - Treatment of patients with major depressive disorder
  - Treatment of patients with schizophrenia
  - Treatment of patients with substance use disorders

Quality Improvement Program Website[43]

UCare's quality improvement program website is organized by 'quality highlights' which includes the MCO's mission to improve the health of their members by addressing health equity and health disparities. The website also presents the results of the MCOs most current Medicare star ratings and NCQA health plan accreditation review. UCare's most current quality management description, evaluation and work plan are accessible through the website.

Performance Measures

Information Systems Capabilities Assessment

The 2020 HEDIS FAR for MY 2019 produced by Advent Advisory Group indicated that UCare met all of the requirements to successfully report HEDIS data to DHS. **Table 63** displays the results of the IS audit.

Table 63: UCare Compliance with Information System Standards

Information System Standard	Review Result
1.0 Medical Services Data	Met
2.0 Enrollment Data	Met
3.0 Practitioner Data	Met
4.0 Medical Record Review Processes	Met
5.0 Supplemental Data	Met
6.0 Data Preproduction Processing	Met
7.0 Data Integration and Reporting	Met

HEDIS – Quality, Timeliness and Access

Due to the coronavirus disease of 2019 (COVID-19) outbreak and in accord with NCQA recommendations, DHS and MDH allowed Medicaid MCOs to request a waiver to report audited HEDIS MY 2018 hybrid rates if they were not able to complete HEDIS MY 2019 hybrid medical record chart reviews according to NCQA technical specifications.

[43] UCare Quality Improvement Program Website: https://home.ucare.org/en-us/about-us/quality-highlights/

UCare's waiver to report 2019 HEDIS MY 2018 hybrid rates for HEDIS MY 2019 was approved. All HEDIS rates in **Table 64** were administratively calculated by DHS.

UCare HEDIS rates are displayed in **Table 64**. The results of the MCO's Measure Matrix analysis are presented in **Figure 11**.

Table 64: UCare HEDIS Performance – Reporting Years 2018, 2019 and 2020

HEDIS Measures	UCare 2018 HEDIS MY 2017	UCare 2019 HEDIS MY 2018	UCare 2020 HEDIS MY 2019	*QC 2020* National Medicaid Benchmark Met/Exceeded	Statewide Average MY 2019
F&C-MA					
Adolescent Well-Care Visit (12-21 Years)	29.9%	41.7%	44.5%	10th	42.6%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)	79.8%	83.4%	83.8%	75th	82.8%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)	83.8%	87.9%	88.2%	66.67th	86.8%
Annual Dental Visit for Children (2-18 Years)	-	57.9%	59.8%	33.33rd	57.4%
Annual Dental Visit for Adults (19-64 Years)	-	37.9%	39.7%	No Benchmark	37.4%
Breast Cancer Screening (50-74 Years)	56.5%	56.8%	59.6%	50th	59.8%
Cervical Cancer Screening (24-64 Years)	62.2%	61.1%	58.3%	33.33rd	56.3%
Childhood Immunization Status: Combo 3 (2 Years)	67.6%	53.6%	47.1%	<10th	53.0%
Children and Adolescents' Access to PCPs (12-24 Months)	97.4%	95.7%	96.4%	50th	96.3%
Children and Adolescents' Access to PCPs (25 Months-6 Years)	85.3%	89.2%	89.4%	50th	88.5%
Children and Adolescents' Access to PCPs (7-11 Years)	87.0%	84.2%	92.0%	50th	91.7%
Children and Adolescents' Access to PCPs (12-19 Years)	87.7%	87.4%	92.0%	66.67th	91.9%
Chlamydia Screening in Women (16-24 Years)	44.2%	60.2%	59.3%	50th	55.1%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)	86.1%	87.9%	87.1%	33.33rd	84.0%
Well-Child Visits in the First 15 Months of Life (6+ Visits)	65.9%	60.4%	61.0%	10th	64.2%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	61.4%	66.0%	67.9%	10th	65.9%

MY= measurement year; QC= NCQA 2020 Quality Compass MY 2019; PCPs= primary care providers.
All rates were calculated by DHS using the administrative methodology.
Note 1: HEDIS hybrid rates are not reported by the MCO because of NCQA reporting changes due to COVID-19. See note on pg. 19. HEDIS Hybrid measures include Adult BMI Assessment, Comprehensive Diabetes Care: Eye Exam.
Note 2: The measure 'Medication Management for People With Asthma (5-64 years)' is no longer included in this report.
Note 3: The NCQA benchmark used for the Annual Dental Visit for Children represents an expanded age group (2-20 year olds).

Table 64: UCare HEDIS Performance – Reporting Years 2018, 2019 and 2020 (Continued)

HEDIS Measures	UCare 2018 HEDIS MY 2017	UCare 2019 HEDIS MY 2018	UCare 2020 HEDIS MY 2019	*QC 2020* National Medicaid Benchmark Met/Exceeded	Statewide Average MY 2019
MNCare					
Adolescent Well-Care Visit (12-21 Years)	14.3%	24.2%	28.0%	<10th	25.4%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)	78.4%	80.1%	81.9%	66.67th	82.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)	82.5%	88.2%	87.5%	50th	88.4%
Annual Dental Visit for Children (2-18 Years)	-	53.5%	54.7%	25th	54.9%
Annual Dental Visit for Adults (19-64 Years)	-	39.2%	40.8%	No Benchmark	40.0%
Breast Cancer Screening (50-64 Years)	57.7%	62.5%	62.4%	66.67th	64.9%
Cervical Cancer Screening (24-64 Years)	60.7%	57.7%	56.1%	25th	54.7%
Children and Adolescents' Access to PCPs (12-24 Months)	Small Sample	Small Sample	Small Sample	Not Applicable	96.9%
Children and Adolescents' Access to PCPs (25 Months-6 Years)	Small Sample	89.5%	91.7%	75th	91.2%
Children and Adolescents' Access to PCPs (12-19 Years)	Small Sample	Small Sample	88.7%	33.33rd	89.4%
Chlamydia Screening in Women (16-24 Years)	Small Sample	56.4%	61.9%	50th	55.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)	95.2%	92.1%	91.5%	75th	89.0%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	Small Sample	69.5%	71.4%	50th	71.5%

MY= measurement year; QC= NCQA 2020 Quality Compass MY 2019; PCPs= primary care providers.
All rates were calculated by DHS using the administrative methodology.
Note 1: HEDIS hybrid rates are not reported by the MCO because of NCQA reporting changes due to COVID-19. See note on pg. 19. HEDIS Hybrid measures include Adult BMI Assessment, Comprehensive Diabetes Care: Eye Exam.
Note 2: The measure 'Medication Management for People With Asthma (5-64 years)' is no longer included in this report.
Note 3: The NCQA benchmark used for the Annual Dental Visit for Children represents an expanded age group (2-20 year olds).

Table 64: UCare HEDIS Performance – Reporting Years 2018, 2019 and 2020 (Continued)

HEDIS Measures	UCare 2018 HEDIS MY 2017	UCare 2019 HEDIS MY 2018	UCare 2020 HEDIS MY 2019	*QC 2020* National Medicaid Benchmark Met/Exceeded	Statewide Average MY 2019
MSHO					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)	98.0%	98.2%	98.4%	95th	98.3%
Breast Cancer Screening (65-74 Years)	61.6%	62.5%	65.6%	75th	64.6%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)	95.9%	90.8%	92.1%	75th	92.2%
MSC+					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)	95.6%	94.0%	95.1%	75th	88.1%
Breast Cancer Screening (65-74 Years)	42.2%	39.7%	41.1%	<10th	40.4%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)	85.0%	81.0%	84.0%	10th	65.8%
SNBC					
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)	92.8%	92.9%	93.2%	95th	92.7%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)	96.5%	96.4%	96.9%	95th	96.4%
Breast Cancer Screening (50-64 Years)	59.2%	57.1%	58.4%	33.33rd	53.3%
Cervical Cancer Screening (24-64 Years)	48.6%	50.4%	44.4%	<10th	41.3%
Chlamydia Screening in Women (16-24 Years)	43.2%	43.1%	41.9%	<10th	41.1%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)	87.7%	84.9%	86.7%	25th	80.6%

MY= measurement year; QC= NCQA 2020 Quality Compass MY 2019; PCPs= primary care providers.
All rates were calculated by DHS using the administrative methodology.
Note 1: HEDIS hybrid rates are not reported by the MCO because of NCQA reporting changes due to COVID-19. See note on pg. 19. HEDIS Hybrid measures include Adult BMI Assessment, Comprehensive Diabetes Care: Eye Exam.
Note 2: The measure 'Medication Management for People With Asthma (5-64 years)' is no longer included in this report.

Figure 11: UCare 2020 HEDIS Measure Matrix

2018 – 2019 Rate Change	Statewide Average Statistical Significance Comparison		
	Below Average	**Statewide Average**	**Above Average**
	C	**B** ▪ Annual Dental Visit-Adult (MNCare) ▪ Adolescent Well-Care Visit (MNCare) ▪ Breast Cancer Screening (MSHO)	**A** ▪ Annual Dental Visit-Adult (F&C-MA) ▪ Annual Dental Visit-Children (F&C-MA) ▪ Adolescent Well-Care Visit (F&C-MA) ▪ Comprehensive Diabetes Care-HbA1c Testing (SNBC) ▪ Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (F&C-MA)
	D ▪ Well-Child Visits in the First 15 Months of Life-6+ Visits (F&C-MA)	**C** ▪ Annual Dental Visit-Children (MNCare) ▪ Breast Cancer Screening (F&C-MA, MSC+, MNCare) ▪ Comprehensive Diabetes Care-HbA1c Testing (MSHO) ▪ Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (MNCare)	**B** ▪ Breast Cancer Screening (SNBC) ▪ Cervical Cancer Screening (MNCare) ▪ Comprehensive Diabetes Care-HbA1c Testing (F&C-MA, MNCare, MSC+) ▪ Chlamydia Screening in Women (F&C-MA, MNCare)
	F ▪ Childhood Immunization Status (F&C-MA)[44]	**D**	**C** ▪ Cervical Cancer Screening (F&C-MA, SNBC)

Key to the Measure Matrix

[44] IPRO and DHS will follow-up to investigate and better understand the observed differences in the administrative rates reported by UCare. To provide year-to-year trends for plans who sought exemptions from hybrid reporting requirements for the 2020 HEDIS reporting period, the administrative rates calculated by DHS were used for trending and analysis. DHS verified that the CIS data in the ATR are augmented with data from the Minnesota Immunization Information Connection (MIIC). DHS and IPRO are confident that the CIS rates presented in the ATR are valid.

A	Notable performance. MCO may continue with internal goals.
B	MCOs may identify continued opportunities for improvement, but no required action.
C	MCOs should identify opportunities for improvement, but no immediate action required.
D	Conduct root cause analysis and develop action plan.
F	Conduct root cause analysis and develop action plan.

Table 65: UCare CAHPS Performance – 2018, 2019 and 2020

CAHPS Measures	UCare CAHPS 2018	UCare CAHPS 2019	UCare CAHPS 2020	*QC 2020* National Medicaid Benchmark Met/Exceeded	2020 Statewide Average
F&C-MA					
Getting Needed Care*	84.2%	83.0%	79.4%	10th	81.7%
Getting Care Quickly*	80.5%	85.7%	81.0%	33.33rd	83.8%
How Well Doctors Communicate*	93.3%	93.3%	95.2%	75th	94.7%
Customer Service*	87.1%	87.0%	86.0%	<10th	88.3%
Shared Decision Making*	82.2%	83.8%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	55.5%	48.7%	54.9%	25th	52.5%
Rating of Personal Doctor**	69.7%	72.8%	72.2%	66.67th	71.6%
Rating of Specialist Seen Most Often**	74.7%	59.5%	65.0%	10th	63.7%
Rating of Health Plan**	63.8%	58.8%	61.6%	33.33rd	56.8%
MNCare					
Getting Needed Care*	83.9%	82.4%	81.1%	25th	83.3%
Getting Care Quickly*	84.0%	79.1%	80.7%	25th	83.2%
How Well Doctors Communicate*	95.9%	94.6%	96.7%	95th	96.9%
Customer Service*	77.6%	85.0%	88.6%	33.33rd	88.6%
Shared Decision Making*	86.4%	82.7%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	60.4%	57.5%	52.1%	10th	52.2%
Rating of Personal Doctor**	72.7%	68.6%	72.6%	75th	71.5%
Rating of Specialist Seen Most Often**	68.2%	65.2%	64.2%	10th	62.7%
Rating of Health Plan**	55.1%	57.1%	55.8%	10th	50.9%

F&C-MA Response Rate = 19.71%. Sample Size = 1,350. Complete Surveys = 260.
MNCare Response Rate = 27.55%. Sample Size = 1,350. Complete Surveys = 356.
* Measure represents the percent of members who responded "yes," "usually" or "always."
** Ratings range from 0 to 10. This measure represents the percent of members who responded "9" or "10."

Table 65: UCare CAHPS Performance – 2018, 2019 and 2020 (Continued)

CAHPS Measures	UCare CAHPS 2018	UCare CAHPS 2019	UCare CAHPS 2020	*QC 2020* National Medicaid Benchmark Met/Exceeded	2020 Statewide Average
MSC+					
Getting Needed Care*	80.1%	84.3%	82.0%	33.33rd	86.1%
Getting Care Quickly*	79.7%	82.8%	82.5%	33.33rd	86.2%
How Well Doctors Communicate*	91.6%	91.3%	94.7%	75th	94.9%
Customer Service*	79.7%	88.6%	88.8%	33.33rd	90.1%
Shared Decision Making*	80.8%	85.1%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	51.1%	51.4%	58.4%	50th	56.7%
Rating of Personal Doctor**	60.5%	70.1%	74.0%	75th	74.3%
Rating of Specialist Seen Most Often**	64.4%	65.3%	67.2%	25th	71.6%
Rating of Health Plan**	52.5%	59.0%	61.3%	33.33rd	62.4%
SNBC					
Getting Needed Care*	86.0%	82.3%	82.7%	25th	83.6%
Getting Care Quickly*	82.9%	83.6%	82.9%	33.33rd	84.7%
How Well Doctors Communicate*	94.2%	92.2%	94.7%	75th	93.9%
Customer Service*	88.9%	88.4%	85.9%	<10th	89.5%
Shared Decision Making*	79.9%	82.6%	Retired	Not Applicable	Not Applicable
Rating of All Health Care**	48.5%	51.3%	54.3%	25th	53.0%
Rating of Personal Doctor**	71.2%	68.3%	73.1%	75th	72.3%
Rating of Specialist Seen Most Often**	75.0%	64.7%	64.0%	10th	66.9%
Rating of Health Plan**	59.6%	62.8%	59.0%	25th	58.3%

MSC+ Response Rate = 29.70%. Sample Size = 1,350. Complete Surveys = 343.
SNBC Response Rate = 36.38%. Sample Size = 1,350. Complete Surveys = 466.
* Measure represents the percent of members who responded "yes," "usually" or "always."
** Ratings range from 0 to 10. This measure represents the percent of members who responded "9" or "10."

UCare Findings and Recommendations

Strengths

- **Compliance –**
    - UCare was fully compliant with the standards of *Title 42 CFR Part 438 Managed Care Subpart D* and *Title 42 CFR § 438.330*.
    - UCare was fully compliant with state standards reviewed under the TCA.
- **PIP** – UCare designed and conducted a PIP that met the standards of *Title 42 CFR 438.330(d)* and *Section 7.2* of the DHS model contract for MCOs.
- **Financial Withhold** – UCare achieved fully points for the SNBC program.
- **ISCA –** UCare met all IS requirements of the HEDIS Compliance Audit and successfully reported HEDIS data.
- **Quality of Care (HEDIS) –** UCare demonstrated strong performance in the following areas of care:
    - F&C-MA
        - Annual Dental Visit-Adult
        - Annual Dental Visit-Children
        - Adolescent Well-Care Visit
        - Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life
    - SNBC
        - Comprehensive Diabetes Care-HbA1c Testing

Opportunities for Improvement

- **Compliance –**
    - **QAE:** UCare received one (1) recommendation and five (5) deficiencies for compliance with state standards.
- **Financial Withhold** – UCare did not earn full points for the F&C-MA, MNCare, MSHO, and MSC+ programs. The MCO did not meet the target goal for the following measures:
    - F&C-MA and MNCare
        - Annual Dental Visit for Children (aged 1-20 years)
        - Annual Dental Visit for Adults (aged 21-64 years)
        - Provider Network Equity: FFS vs. MCO
        - Emergency Department Utilization Rate
        - Hospital 30-Day Readmission Rate
    - MSHO and MSC+
        - Annual Dental Visit Rate (aged 18-64 years)
    - SNBC
        - Annual Dental Visit Rate (aged 18-64 years)

- **Quality of Care (HEDIS) –** UCare demonstrates an opportunity for improvement in the following areas:
    - F&C-MA:
        - Childhood Immunization Status-Combo 3
        - Well-child Visits in the First 15 Months of Life-6+ visits

Recommendations

- **Financial Withhold** –
    - In addition to the dental improvement activities described in UCare's response to the previous year's recommendation, UCare should consider collaborating with the other MCOs to develop a broader plan for addressing the shortage of dental providers across the state.
    - Concerning member emergency department use and 30-day hospital readmissions, UCare should identify potential partnerships within the Minnesota healthcare setting to support members post-discharge.
- **Quality of Care (HEDIS) –** Although UCare has a robust strategy for improving childhood immunizations, this area continues need improvement. Low childhood immunization and well-child rates may be the result of access issues. UCare should conduct routine network adequacy evaluations to identify gaps that may prevent members from accessing care.

CHAPTER 5: MHCP FINDINGS AND RECOMMENDATIONS

Annually, DHS evaluates statewide performance using the HEDIS administrative methodology for select measures. DHS also contracts with a certified-CAHPS vendor to annually assess statewide member satisfaction. To determine common strengths and opportunities for improvement across all MCOs participating in the MHCP, IPRO compared the HEDIS and CAHPS statewide averages to the national Medicaid benchmarks presented in the *Quality Compass* 2020. Measures performing at or above the 75th percentile were considered strengths; measures performing at the 50th percentile were considered average, while measures performing below the 50th percentile were identified as opportunities for improvement. Common strengths and opportunities for improvement are discussed below. Statewide HEDIS and CAHPS performance, as well as IPRO's assessment, are displayed in **Table 66** and **Table 67**, respectively.

MHCP COMMON STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT

Common **strengths of the MHCP** include: access to primary care for adults, and member satisfaction with personal doctor. MHCP rates for the following HEDIS and CAHPS measures met or exceeded the 75th percentile:

- *Adults' Access to Preventive/Ambulatory Health Services* (all age groups)
- *How Well Doctors Communicate*
- *Rating of Personal Doctor*

Common **MHCP opportunities for improvement** include: child/adolescent care, women's health screenings, and member satisfaction with of health plan. MHCP rates for the following HEDIS and CAHPS measures were below the 50th percentile:

- *Adolescent Well-Care Visit* (12-21 Years)
- *Annual Dental Visit for Children (2-18 Years)*
- *Breast Cancer Screening* (50-74 Years)
- *Cervical Cancer Screening* (24-64 Years)
- *Childhood Immunization Status: Combo 3* (2 Years)
- *Chlamydia Screening in Women* (16-24 Years)
- *Comprehensive Diabetes Care: HbA1c Testing* (18-75 Years)
- *Asthma Medication Ratio (5-64 Years)*
- *Well-Child Visits in the First 15 Months of Life* (6+ Visits)
- *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life* (3-6 Years)
- *Customer Service*
- *Rating of All Health Care*
- *Rating of Specialist Seen Most Often*
- *Rating of Health Plan*

Table 66: MHCP HEDIS Performance – Measurement Year 2017, 2018 and 2019

HEDIS Measures	MHCP HEDIS MY 2017	MHCP HEDIS MY 2018	MHCP HEDIS MY 2019	Performance Assessment based on *QC 2020* National Medicaid Benchmarks[1]
Adolescent Well-Care Visit (12-21 Years)	35.0%	36.8%	41.9%	**Opportunity**
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)	84.5%	83.4%	83.8%	**Strength**
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)	90.2%	90.1%	89.4%	**Strength**
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)	95.1%	94.6%	94.8%	**Strength**
Annual Dental Visit for Children (2-18 Years)	-	53.8%	54.6%	**Opportunity**
Annual Dental Visit for Adults (19-64 Years)	-	38.8%	39.5%	**Not Available**
Breast Cancer Screening (50-74 Years)	56.2%	57.8%	58.1%	**Opportunity**
Cervical Cancer Screening (24-64 Years)	56.1%	55.8%	53.8%	**Opportunity**
Childhood Immunization Status: Combo 3 (2 Years)	63.5%	56.6%	53.1%	**Opportunity**
Children and Adolescents' Access to Primary Care Practitioners (12-24 Months)	96.6%	95.1%	96.3%	**Average**
Children and Adolescents' Access to Primary Care Practitioners (25 Months-6 Years)	90.2%	87.1%	88.6%	**Average**
Children and Adolescents' Access to Primary Care Practitioners (7-11 Years)	92.3%	90.1%	91.7%	**Average**
Children and Adolescents' Access to Primary Care Practitioners (12-19 Years)	93.0%	91.2%	91.9%	**Average**
Chlamydia Screening in Women (16-24 Years)	52.3%	54.2%	54.8%	**Opportunity**
Comprehensive Diabetes Care: HbA1c Testing (18-75 Years)	85.8%	85.8%	83.4%	**Opportunity**
Asthma Medication Ratio (5-64 Years)	63.3%	64.2%	61.4%	**Opportunity**
Well-Child Visits in the First 15 Months of Life (6+ Visits)	63.8%	59.4%	64.2%	**Opportunity**
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (3-6 Years)	63.6%	60.2%	65.9%	**Opportunity**

[1] Performance Assessment: Strength = at or above the 75th percentile; Average = at or between the 74th and 50th percentiles; Opportunity = below the 50th percentile.
[2] The QC 2020 benchmark is for ages 2-20 years.
MY= measurement year.
Note 1: MHCP rates were calculated by DHS using the administrative methodology.
Note 2: The NCQA benchmark used for the Annual Dental Visit for Children represents an expanded age group (2-20 year olds).
Color Key: Rate at or above the 75th percentile | Rate at or above the 74th and 50th percentiles | Rate below the 50th percentile

Table 67: MHCP CAHPS Performance – 2019 and 2020

CAHPS Measures	MHCP CAHPS 2019[1]	MHCP CAHPS 2020[1]	Performance Assessment based *QC 2020* National Medicaid Benchmark Met/Exceeded[2]
Getting Needed Care*	83.9%	84.1%	**Average**
Getting Care Quickly*	84.4%	84.7%	**Average**
How Well Doctors Communicate*	94.1%	94.9%	**Strength**
Customer Service*	87.7%	89.1%	**Opportunity**
Shared Decision Making*	82.3%	Retired	**Not Applicable**
Rating of All Health Care**	54.6%	53.4%	**Opportunity**
Rating of Personal Doctor**	71.4%	72.4%	**Strength**
Rating of Specialist Seen Most Often**	66.4%	66.9%	**Opportunity**
Rating of Health Plan**	60.1%	57.1%	**Opportunity**

MHCP Response = 29,550. Response Rate = 16.14%.

[1] MHCP rates were calculated by HSAG.

[2] Performance Assessment: Strength = at or above the 75th percentile; Average = at or between the 74th and 50th percentiles; Opportunity = below the 50th percentile.

* Measure represents the percent of members who responded "yes," "always" or "usually."

** Ratings range from 0 to 10. This measure represents the percent of members who responded "9" or "10."

Color Key: Rate at or above the 75th percentile | Rate at or above the 74th and 50th percentiles | Rate below the 50th percentile

CHAPTER 6: FOLLOW-UP TO 2018 ATR RECOMMENDATIONS

MCO Follow-up on Prior Recommendations

Title 42 CFR § 438.364 External quality review results (a)(6) require each annual technical report include "an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has addressed effectively the recommendations for QI made by the EQRO during the previous year's EQR." IPRO requested that each MCO describe how its organization addressed the recommendations from the RY 2018 EQR Technical Report. MCO responses are reported in this section of the report.

BLUE PLUS

- **2018 Recommendation: 2018 Financial Withhold –**
  - Blue Plus should continue its current improvement strategy and identify new (stronger, correlated) variables to reduce emergency department utilization, hospital admissions and hospital readmissions. Although Blue Plus has not met the withhold target for these measures, the health plan reported that rates for these measures were trending downwards.
  - Blue Plus indicates that there remains a shortage of dental providers in the state. To address this shortage, Blue Plus should consider training current network primary care providers to provide preventive oral health services for young members and encourage primary care clinics to add a dentist to the practice. Blue Plus should also outreach to all members who did not receive dental care within the past year to assist the member with identifying a dental provider who is accepting new patients and with making dental appointments.

MCO Response: Emergency Department Utilization - Blue Plus is committed to reducing unnecessary emergency department (ED) utilization and helping members access the care they need. Our goal is for members to receive the right care, at the right time, in the right place. We are tackling this goal through multiple avenues, including member education, program design, and provider value-based programs.

Blue Plus data, analytics and predictive modeling tools allow us to identify members with likelihood of preventable emergency use, inpatient utilization, or at risk for more restrictive placement. These tools are then used to prioritize members for care management outreach through one of our care management programs.

For example, our Emerging Risk Model (ERM) tool proactively identifies members with high risk of becoming super-utilizers. Once identified, care management staff reach out to Members seeking to educate them on alternatives of care, including telehealth, identify barriers they may be facing accessing primary and preventive services. They help members identify primary care providers, explain covered services, and show them how to navigate the care delivery system.

A key component in all of our care management programs is to continuously seek opportunities to connect members to a provider. All care management assessments and care-planning activities capture a member's current providers and support provider coordination in care planning activities for members already engaged in treatment. When members do not have a current provider, we connect them to the right provider for their specific needs.

We also continuously identify new candidates for care management outreach through our Continuous Case Finding (CCF) process that evaluates our entire member population monthly. This process helps us monitor each member's health status by continuously synthesizing member data (such as diagnoses, prescriptions, hospitalizations, and emergency department encounters).

Examples of our predictive modeling tools that support the proactive identification of members likely to use the ED or who are at risk of inpatient services or a more restrictive setting include:

- Likelihood of Inpatient Admission (LIPA). Predicts the likelihood of an inpatient admission within 60 days, and helps us identify members at risk of a PPA.
- Low Intensity Emergency Room Risk (LIER). Predicts the likelihood of an Emergency room visit in the next three months for a low-intensity condition.
- Readmission Risk. Recalculates based on the inpatient daily census report to determine the likelihood of readmission, and helps us identify members at risk of a PPR.
- BH Readmission. Predicts the likelihood of a member having an unplanned behavioral health hospital readmission within 60 days.
- Early Warning Tool. Identifies new members (less than six months enrolled) with limited claims data who have the potential to use services at a disproportionately high rate.

The High Emergency Department Utilization Program is another way Blue Plus is working to reduce emergency department visits. This program identifies underlying reasons members are using the emergency department. We then work with the member to find solutions that will help them access the care and treatment they need, thereby decreasing future emergency department use. This program is centered on connecting members with primary care, preventive services, and self-management. Case Managers reach out to members to provide information for urgent care or other providers as appropriate, help them identify when to emergency department is warranted, and improve their health literacy. Members who agree to comprehensive Care Management continue with a dedicated Case Manager, while other members (upon outreach) are supported in selecting a primary care provider, addressing transportation needs, and setting appointments.

The ER Lane Program focuses on decreasing improper use of the emergency room. Case Managers identify high Emergency Room utilizers for this initiative and provide telephonic outreach to the identified members to provide education on the proper use of the Emergency Room and connect members to case management when needed. Case managers monitor members by review of utilization patterns, identifying and addressing barriers and gaps in care. They work in collaboration with the member's provider when necessary. Regular clinical rounding occurs on these members. Trying to Reach you letters, and educational materials are mailed to members when indicated. Metric reporting is focused on Emergency Room diversion, particularly related to members who are incorrectly utilizing the Emergency Room.

Blue Plus first launched its Medicaid Provider Value-Based Program (VBP) in 2015 to focus specifically on improving health outcomes, increasing quality of care and managing costs in our F&C-MA and MNCare populations. Currently, the program serves over 65% of attributed members. ED utilization has been a metric in the Medicaid VBP since its inception. As part of the Medicaid VBP, Blue Plus regularly reviews performance with participating care systems and provides member-level

reporting on at least a quarterly basis. Blue Plus and the care system work together to identify opportunities for improvement.

In 2019, data shows positive results when members are attributed to VBP participating providers. Rates of ED utilization for VBP attributed members was 42/1,000mm compared to 50/1,000 for members attributed to non-VBP participating providers. ED utilization was retired from the VBP quality program in 2020, but we still track and share data on ED utilization trends as part of overall value-based program reporting.

Hospital Readmission Rates

Blue Plus also is committed to reducing unnecessary readmissions by working to ensure members who have been hospitalized have the tools and resources they need to experience a smooth transition to home or other care setting. As with ED utilization, we are addressing this through a multi-pronged approach.

All cause readmissions has been a metric in our Medicaid VBP since its inception in 2015. As noted above, Blue Plus works closely with care systems participating in the Medicaid VBP to identify opportunities for improvement. This includes reviewing regular member and provider-level reporting on both admissions and readmissions. In 2019, rates for All-Cause Readmissions was slightly lower for members attributed to providers participating in our Medicaid VBP at a rate of 13/1,000mm (per thousand member months) compared to 14/1,000mm for attributed members who went to non-VBP providers. All-Cause Readmissions was included in 2020 and will continue to be included as a measure within our value-based programs in 2021, however measurement will be based on observed to expected performance in alignment with NCQA HEDIS measurement beginning in 2020.

Post-Discharge Management (PDM) is part of our continuum of care that uses personal outreach and short-term interventions to help prevent readmissions. We use data analytics, a Readmission Score generated through our predictive modeling, and a review of the member's admitting information to identify members in an inpatient setting who are at high risk for readmission. A PDM Case Manager (nurse or behavioral health clinician) contacts the member at the point of admission when feasible, or as soon as possible following discharge, and engages them in at a minimum of weekly calls for the first 30 days. The Case Manager works closely with the member's providers, behavioral health provider as applicable, hospital discharge planner or social worker, and our UM clinicians to support the member's discharge home or to an alternative and most integrated setting. Together, they assure completion of all post-discharge activities based on the member's individualized needs.

The Rapid Rounds Program focuses on decreasing utilization related to Emergency Room and Inpatient Admissions. Case Managers identify and engage members with complex needs and high utilization into case management in an effort to improve member outcomes and reduce utilization rates.

Each month approximately 80-100 members are identified for rapid rounds. Rapid rounds is a forum for case managers to present cases to a team of Medical Directors, Case Managers and Social Workers to brainstorm on specific member interventions to drive improved member outcomes and reduced costs for high risk and complex members. The goal is to reduce overall utilize trends, improve member overall quality of life and promote a reduction in utilization (emergency room, inpatient admissions and readmissions).

We will continue to promote our 24-hour nurse line that members can use free of charge.

In 2019, we met goal for the withhold, and early data from 2020 continues to show a positive trend in lower all-cause readmission rates for members attributed to VBP providers.

Dental Care for All Ages

Blue Plus recognizes the importance of annual dental care for all age groups. Regular dental visits are essential for the maintenance of healthy teeth and gums and can identify oral health issues early when treatment is most successful. Blue Plus has initiated member interventions across all ages to encourage an annual dental visit, as outlined below. However, significant barriers remain to improving dental access for Medicaid members across the state.

In 2019, Delta dental hired four Blue Plus dental coordinators who field incoming calls from our members in order to make it seamless for our members to find dentists and schedule appointments with one call. Coordinators also assist members coordinate transportation and interpreter services as needed, and they provide reminder calls 48 hours prior to the appointment to decrease appointment no-show rates.

The Delta coordinator care (DCC) team continues to assist each member until their treatment is complete and provides confirmation and follow up calls through the duration of the member's treatment plan.

The DCC team also works closely with our Blue Plus Case Managers. If the case managers determine a particular member needs assistance with dental care based on the assessment conducted for the member, outreach and care coordination services are expeditiously provided.

All staff members at Delta Dental, including Customer Service Agents and Care Coordinators are required to complete monthly training exercises focused on diversity, inclusion, and cultural understanding and are well equipped to assist members from diverse backgrounds.

To encourage healthy dental behaviors from an early age, Blue Plus included the annual dental visit in its Healthy Rewards Program, a member incentive program that rewards healthy behaviors. Members age 2 – 20 are eligible to receive a $25 incentive if they complete an annual dental visit. Blue Plus supplements the member reward with outreach via mail reminding members of the importance of regular dental care. For our MSHO and MSC+ population, Blue Plus worked with its

care coordinators to educate members about oral health. Throughout 2018, Blue Plus provided care coordinators gap in care lists that identified MSHO and MSC+ members who were due for their Assessment and had a gap in an annual dental visit. During the assessment visit, care coordinators educated members about the importance of regular preventive dental care, addressed any barriers the member may be experiencing, and provided the member with a flyer illustrating the importance of oral health for overall health. In addition, supplemental benefits of an electronic toothbrush and replacements heads were added along with an extra preventive dental visit and root planning and scaling coverage for MSHO members. In 2019, more robust supplemental benefits for dental were added to include: dental crowns, root canals and re-treats, full mouth x-rays and perio-maintenance dental visits for MSHO members.

Despite these efforts, Blue Plus's annual dental visit rates have remained relatively flat. In 2019, we partnered with Southside Dental Clinic to offer mobile dental servicers in greater Minnesota. In addition, Blue Plus plans to expand its member reward to F&C – MA and MNCare members of all ages. To target our outreach more effectively, we will use analytic tools to map hotspots of underutilization across the state. While important, these interventions do not address the significant dental access issues that exists in Minnesota. Minnesota has a total of 124 Dental Health Professional Shortage Areas across the state. Blue Plus is working with Delta Dental and other dental providers and health programs to address these dental health shortage needs and increase access to dental services, particularly in rural and Greater Minnesota.

- **2018 Recommendation:** HEDIS (Quality of Care) – With regard to women's health and well visits for children and adolescents, Blue Plus should examine the adequacy of its provider network to determine if access and/or quality issues exist. Blue Plus should also enhance its quality improvement strategy to include multiple methods of member outreach, including community events, social media, direct contact via telephone, etc.

  MCO Response: Child and Adolescent Well-Care Visits - The American Academy of Pediatrics and Bright Futures recommend annual well-care visits during adolescence to promote healthy behaviors, prevent risky ones, and detect conditions that can interfere with a teen's physical, social, and emotional development. Efforts to improve the rate of adolescent well-care visits among our Medicaid members are highlighted below.

  Blue Plus uses multiple channels to educate parents/guardians of members on the importance of an annual adolescent well-care visit. In 2018, this included targeted outreach through email and telephone. To further enhance our member outreach efforts, in 2019 Blue Plus implemented preventive health reminder mailings and overdue service reminder postcards promoting child and teen check-ups. Adolescent well-care visits and adolescent immunizations also continue to be a part of Blue Plus's Healthy Rewards Program. For the Child and Teen Check-Up program in 2019, over 149,000 preventive health reminders have been sent to members and close to 134,000 overdue reminders.

To partner more effectively with providers to improve adolescent well care across the state, Blue Plus added the HEDIS Immunizations for Adolescents measure to its Medicaid Value Based Program in 2019. Blue Plus provides monthly gaps in care reporting to participating providers to help support their improvement efforts in this area. Blue Plus is also an active contributor to the Metro Action Group (MAG) Collaborative and all other regional C &TC groups around the state. Blue Plus participates in clinic training with counties on C &TC updates including billing codes and procedures.

Blue Plus evaluates its provider network adequacy and accessibility annually. This group shows that 100% of its members have the appropriate access to practitioners and exceeds the Blue Plus appointment accessibility requirements. No gaps were identified for this group in 2018 or 2019.

Blue Plus uses multiple channels to educate women on the importance of annual preventive care, which include breast cancer screening, cervical cancer screening, chlamydia screening, and maternal care. We leverage member calls to provide health reminders when it appears that a member is due for a preventive care visit using our claims data. Blue Plus's Healthy Rewards Program incentives women to complete their screenings. In addition, Blue Plus has a social media presence, in which we posts stories on health care topics, such as the importance of mammograms in October.

Blue Plus continues to participate in the statewide community-based Minnesota Chlamydia Partnership (MCP) to raise awareness of the increasing numbers of young people contracting sexually transmitted infections (STI) throughout the state. A large focus of MCP's work is promotion of annual STI testing and treatment. MCP, along with community clinics and organizations, sponsors events that offer confidential and free/low-cost testing. One such event is the Annual STI Testing Week led by the Community Restoring Urban Youth Sexual Health (CRUSH) group.

Our value-based agreements with our providers also include breast cancer screening, cervical cancer screening, and chlamydia screening to improve rates across the state. Blue Plus provides participating care systems monthly gap in care reporting to facilitate member outreach and education. We also highlight any disparities in providers' rates between their commercial and Medicaid populations, thus giving them further insight into their performance and the needs of their patient population. In 2019, the first year these measures were included in the Medicaid VBP, rates for breast cancer screening and chlamydia screening remained stable, where rates for cervical cancer screening increased from 57% to 59% when compared with baseline performance (2018 dates of service). Blue Plus has a team of clinicians that offers consultation and education to providers on quality performance and improvement. They meet regularly with providers participating in our value-based programs and offer expertise on the HEDIS measures included as metrics in those programs. These measures remain in the program for 2020 and will continue to be in the program for 2021.

Blue Plus evaluates its provider network adequacy and accessibility annually. This group shows that 100% of its members have the appropriate access to practitioners and exceeds the Blue Plus appointment accessibility requirements. No gaps were identified for this group in 2018 or 2019.

- **2018 Recommendation:** CAHPS (Member Satisfaction) - Blue Plus should conduct root cause analysis on all poorly performing CAHPS® measures and implement initiatives to address identified barriers.

  MCO Response: CAHPS (Member Satisfaction) - Blue Plus conducts an evaluation at least annually that includes both a qualitative and a quantitative analysis of member experience information, including CAHPS results. The qualitative analysis includes an examination of deficiencies or processes that may present barriers to improvement or cause failure to reach a stated goal. The quantitative analysis involves a comparison of numeric results against a standard or benchmark, trended over time using charts, graphs or tables.

  Our 2018 and 2019 evaluations of our member experience data led us to focus on the following areas for identification of barriers and development of opportunities:

  - Customer Service Provided Needed Information or Help
  - Got check-up or routine appointment as soon as needed
  - Got appointment with specialist as soon as needed
  - Easy to fill out forms

  To improve member experience relative to Customer Service and ease of filling out forms, Blue Plus implemented such projects as expansion of its Retail Center classes on health plan benefits and development of advanced training on benefit structures for customer service staff. To address member experience relative to members getting routine or specialist care as soon as needed, Blue Plus projects included a continued promotion of telehealth and how to access it as a resource, as well as additional customer service training and enhancements to the online Find a Doctor tool to help members navigate access to their benefit plan's network and health care appointments.

HEALTHPARTNERS

- **2018 Recommendation:** 2018 Financial Withhold –
  - In regard to hospital admissions and readmissions, HealthPartners should continue with the interventions strategy described in the Health Plan's response to the previous year's recommendation. HealthPartners should identify the most effective interventions and identify ways in which these interventions can be expanded upon.
  - HealthPartners indicates access to dental providers is an ongoing issue for MHCP members. To address this gap in care, HealthPartners should consider training current network primary care providers to provide preventive oral health services for young members.

MCO Response: Admissions and Readmissions: Efforts to decrease hospital admissions and readmissions continue to be a challenge for HealthPartners. HealthPartners senior leadership established a workgroup to examine admission and readmission trends, conduct root cause analysis, identify opportunities for improvement, and determine next steps.

A multi-departmental work group reviewed and analyzed HealthPartners member admission and readmission data. This included review of reports that analyzed utilization, intensity, and top conditions. The work group met to review the data, each time with more robust data analytics. Overall, the inpatient utilization trend and top conditions affecting this trend change each year, and sometimes quarterly, so it is difficult to implement policy changes, outreach, or interventions designed to impact specific conditions which may be driving trend.

- Member access, preference, and education are barriers to engaging in care. Members may avoid preventive or chronic care maintenance until a health issue has escalated to the point of hospitalization. HealthPartners continues to conduct member education and outreach regarding preventive care and appropriate ED use.
- We review every admission for members involved in complex case management to identify if there was a point when we could have taken action to improve the outcome and avoid the admission. Case Managers also work with members who are having planned admissions to ensure that transitions into the hospital and home again go as smoothly as possible. This transition planning includes medication reconciliation, communicating with the primary care provider or other specialists, and assisting with accessing and coordinating additional home resources.
- A chart review of members involved in complex case management who experienced a readmission were examined for missed opportunities. Limited trends were apparent, and the review confirmed that missing a primary care follow-up visit did not appear to be a driver of readmissions for these members.

Initiatives/Interventions

Our findings show that the social determinants of health directly impact utilization of services, including admissions and readmissions. There has been significant research in this area and the workgroup felt it is important to note that impact, especially among our Medicaid membership. In addition, as a health plan, we under-utilize our own internal member support resources such as care coordination and Medication Therapy Management (MTM) services.

Overall, the collaboration between the health plan and our care system to identify high risk members who may be at risk for hospitalization or re-hospitalization is an opportunity to impact this measure. The group examined all current initiatives and made recommendations for additions or enhancements as appropriate.

Disease & Case Management (DCM) Services

Members identified for DCM services include those with complex medical conditions or poorly managed chronic conditions that are at high risk of future hospitalization. Our goal is to improve member self-management of their complex or chronic conditions, thereby reducing risk of future admissions including readmissions. Toward that end, DCM uses the following targeted interventions:

- Post-discharge support for all members participating in DCM services who experience a hospital admission.
- Connection to Medication Therapy Management (MTM) services for members with complex medication regimens or medication adherence concerns.
- Assessment and care planning with interventions tailored to address the member's unique needs, barriers, and identified clinical gaps in care.
- Close collaboration with care team members including primary care physicians (PCPs) and health care home nurses, home care providers, MTM/pharmacy resources, and community based providers.
- Inpatient Case Management services to support real time identification and engagement of high-risk members to ensure milestones and care plans are implemented before discharge.
- Hospital Case Managers refer members to MTM for medication review when appropriate following discharge to ensure medication reconciliation and patient understanding of any medication changes. The Regions Case Management department increased referral goals for HealthPartners Medicaid members to a goal of 60 referrals per month. They met this goal in 9 months in 2018.

Total Cost of Care (TCOC) Arrangement

HealthPartners long-term strategic initiatives are based on the three dimensions of the Triple Aim; health, experience, and affordability as measured by the TCOC. HealthPartners trend management approach is built on a strong foundation of programs that are designed to reduce overuse and

misuse of resources and to improve the value of the services provided to our members. We are continuously working to identify new opportunities to capture TCOC savings.

Provider Interventions: HealthPartners Medical Group (HPMG) and Park Nicollet Clinics receive daily discharge notifications from hospitals. They have implemented outreach processes for post-discharge calls with patients. Care delivery uses an algorithm to identify those who may be at especially high risk for readmission to prioritize patient calls and ensure they are scheduled for follow-up with their clinic in a timely manner. Engagement with the highest risk members continues to be a challenge.

Park Nicollet care system implemented a text-first communication approach to reach patients following discharge. A text message is sent via a texting platform and asks a series of automated questions to help assess a patient's risk for readmission. Based on the patient's answers, the platform automatically notifies the care team of their responses and nurses prioritize those who need attention.

The HPMG/Park Nicollet care system embedded a predictive analytics tool into EPIC in May of 2018. Risk of Unplanned Readmission alerts assist in identifying patients who are at risk of readmission by looking at the following components: age, demographics, diagnosis, medications, order type look-back, lab look-back, and utilization. Inpatient case managers document readmission risk in a note prior to discharge for access by the clinic team.

Network clinics and hospitals are using Community Paramedics (CPs) and Emergency Medical Technicians (EMTs) to conduct home visits to support the member after discharge and reduce the likelihood of readmission. CPs are experienced 911 paramedics with additional education to provide non-emergency care to patients and help manage chronic conditions.

At Regions and Lakeview hospitals, orders for the CP program are made through the EPIC system. The current diagnoses that can be referred to the CP program include CHF, COPD, AMI, pneumonia, and stroke. As the benefits of these visits are recognized, the diagnoses that are targeted for visits continue to expand. Partnerships with Community Health Workers allow additional needs to be addressed. Priority is given to HealthPartners insured members. CP home visits include:

- Measurement of vital signs
- Performing physical exams
- Reviewing upcoming appointments or assistance with scheduling follow up
- Medication reconciliation, education, and compliance checks
- Connecting patients to community resources
- Conducting home safety assessments
- Reinforcement of dietary recommendations

Methodist Hospital's "Good to be Home" program partners with several local fire departments for a one-time post-discharge visit by an EMT.

- Perform blood pressure check and ask you basic questions about health
- Review medications and physician instructions
- Reviewing upcoming appointments or assistance with scheduling follow up
- Ensure access to food and transportation
- Conducting home safety assessments
- Replace smoke alarms or batteries as needed

HealthPartners Community Senior Care program offers care for seniors where the patient is located in their home, a nursing home, transitional care center, or assisted living center.

- Care at Home sends medical teams to the homes of Minnesota Senior Health Options (MSHO) and Medicare Advantage patients at risk of readmission. The care team includes both an advance practice nurse as well as MDs.
- To reduce the likelihood a member will be readmitted for symptom or pain management, care teams ensure that comfort care is provided to the member in their home or wherever they are being discharged to. The medical team works with the staff at the transitional care unit (TCU) or nursing home to provide the appropriate level of symptom management.

Access to dental providers has been identified as an ongoing issue for Medicaid members in MN. Barriers to Medicaid members receiving dental care are well documented. In many areas of the state, there are limited dental clinics, and the clinics may not be accepting new Medicaid members. Dental clinics identify low payment rates and high appointment fail rates as reasons they limit the number of Medicaid members they serve.

HealthPartners collaborates with our primary care network partners to provide fluoride varnish as part of routine Child and Teen Check-ups. The majority of our network clinics have integrated this into their standard of care for well child exams. Our care system has integrated this process into our EPIC system with automatic prompts at appropriate ages when dental varnish should be offered. While this important dental care provided within medical care visits is not included in the dental withhold, it may give parents some assurance of dental protection for their child.

In addition, HealthPartners has implemented these additional interventions to attempt to make progress towards the dental withhold goals.

- To assist members to locate a dentist who is accepting new patients, HealthPartners created a State Public Programs Dental Navigator role within Member Services. Member Services Representatives can look to this navigator for assistance with dental support on complex benefits, provider access, and as a resource for community services when non-plan benefits

are needed. This support lessens the burden on the member to make repeated calls to multiple clinics to find an open clinic.

- HealthPartners Dental Group (HPDG) has a Patient Dental Call Center to respond to incoming requests for dental care and to conduct follow-up for needed services for HPDG patients.
- Staff contacts parents of 1-6 year old PMAP members who have not had a dental appointment in the last year, in an effort to schedule a pediatric exam appointment. This project will continue to connect with 20-25 families per week with a goal of scheduling at least 50% with New Patient Exams.
- In 2018, the Dental Call Center was expanded to add two additional staff to accommodate additional outreach for the DHS Dental withhold. Protocols for scheduling Medicaid members within the HPDG clinics was updated to maximize access opportunities and call center staff received training to schedule accordingly.
- HPDG strategically recruited and hired additional dental staff to serve members at dental clinics with a higher rate of Medicaid patients to increase access to appointment times. In addition to the call center, HPDG added more than 12 FTEs including dentists, dual license ADT/hygienists, and hygienists to improve appointment availability.
- HealthPartners dental staff attended a meeting of staff interpreters to share information on the importance of dental care and the need for members to get preventive care. This will assist them in encouraging their clients to seek dental care. Information was shared on how to schedule dental visits. Some interpreters work at clinics where medical and dental services are co-located, which allows them to further assist members to make appointments.
- A member outreach campaign contacted members who had not had a dental appointment in the past 12 months. Emails were sent to members with the contact information for their attributed dental clinic. Areas of the state were targeted where access to dental care appointments could be clearly identified. In other parts of the state, Member Services continued to work with members individually to access appointments.
- In addition to fielding inbound calls from members, dental call center staff conducted outbound calls to members who had not had a dental visit in the past 12 months to assist them in scheduling an appointment.
- HealthPartners initiated outreach calls to members who visited the ED for dental reasons beginning in May 2019. Dental Call Center staff reached out to metro members, and the Dental Navigator in Member Services contacted members in greater Minnesota. They offered support and assistance to get needed follow-up care after the ER visit.
- HealthPartners dental plan sponsored a year's supply of toothbrushes to the care delivery system to facilitate discussion about the need for the patient to see a dentist for the first time and/or get fluoride varnish.

- HealthPartners dental plan supported the Reach Out and Read program through the purchase of age appropriate books for nine month olds with a dental theme to encourage parents to start their child with dental care at first eruption of teeth.
- Special Needs Basic Care (SNBC) Care Coordinators discuss the importance of dental care during their interactions with members and assist the member in finding a dentist or schedule an appointment when needed.

- **2018 Recommendation:** HEDIS (Quality of Care) – HealthPartners should evaluate the effectiveness of the Asthma Management Program on member medication management. HealthPartners should expand its approach to include members who are not enrolled in the Asthma Management Program.

  MCO Response: Medication Management for people with Asthma, Families & Children (F&C-MA) – Disease Management: Asthma is one of the conditions we support in our core disease management program. We identify members for asthma through our predictive analytics algorithm, via claims, and other sources, including but not limited to electronic medical record (EMR), and health assessment (HA) data. Additionally, we receive referrals from providers, member self-referral, and other HealthPartners departments. Identification stratification occurs with members based on identified risk:

  - Low risk receive periodic educational mailings and access to online asthma management tools.
  - Rising and high-risk members receive telephonic outreach, as well as have access to our online asthma management tools, decision support, and other resources.
  - Members who are identified as high risk with asthma (due to factors such as gaps in care, poor medication adherence, use of ER, co-morbid conditions, etc.) receive outreach from our nurses.

  We outreach telephonically and via letter to engage members into disease management services. We do our best to make call attempts during the first 10 days of the month, at different times a day, and connect with the member's provider to assist with engagement in the event we do not reach the member via phone or letter.

  Members who engage with our Asthma Management Program receive a $25 incentive. This has resulted in increased engagement with the Asthma Management Program.

  - Our PMAP engagement rate for asthma management of those members we reach via the phone and engage into the program is 70% overall engagement.
  - Our overall engagement for members PMAP members identified is 20-25.
  - A focus for asthma management is completion of an Asthma Action Plan and Med Adherence to a bronchodilator. We did make a pivot in 2020 related to COVID, to helping

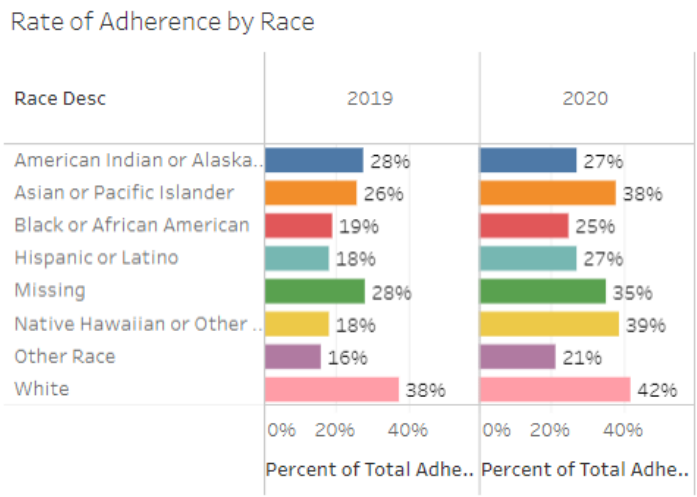
members with asthma in avoiding COVID-19 exposure, as well as how to access care, and connect with providers.

Our goal has been to achieve at least 70% compliance with asthma action plans, and we achieved 79% compliance for our total asthma engaged members. It remains a focus and we will continue to evaluate the goal, reinforce importance, and provide our nurses with tools to assist members with compliance.

- Bronchodilator use
- Asthma Action Plan
- Asthma Control Test >19
- Evidence of PCP visit
- Medication Compliance
- Depression Screening
- Tobacco avoidance
- Evidence of flu shot

Medication Therapy Management: Through HealthPartners Medication Therapy Management (MTM) program, members with uncontrolled asthma are frequently identified for outreach and engagement efforts. Specifically, the proprietary HealthPartners medication risk scoring algorithm reviews members claims history to identify, among numerous other elements, non-adherence to asthma controller medications, ED/hospital utilization, and who don't have consistent primary care. Members are invited to participate in the program, attributed to an MTM provider (based upon where they receive care or fill prescriptions), and their information is shared with the MTM provider to help them engage these at risk members. Furthermore, HealthPartners provides monetary rewards to MTM providers who achieve high levels of member engagement. Once members are engaged in MTM services, care is coordinated with primary care and our disease and case management programs.

To monitor how successful these efforts are, this measure is included in our adherence monitoring reporting. We can monitor this measure by product and within product (PMAP/MNCare) we can stratify by age, gender, and race. Our monitoring shows adherence has improved by 6% from 2019 to 2020, and has improved for almost all racial groups in the same time period.



- **2018 Recommendation:** CAHPS (Member Satisfaction) – HealthPartners should conduct root cause analysis and implement interventions to address identified barriers. The MCO should also evaluate the effectiveness of existing interventions and update and modify them as needed.

  MCO Response: HealthPartners is dedicated to enhancing member experience. In order to do this we monitor our CAHPS scores annually in an effort to identify and address areas of opportunity. HealthPartners has a cross-functional work group which includes leaders from key departments that review CAHPS scores and identify work that is needed or currently underway to address gaps or deficiencies. Below are some of the examples of work that connects to the specific opportunities identified through CAHPS in 2018.

  Rating of the Health Plan: HealthPartners is committed to helping members understand their coverage and benefits. As a result our Marketing Communications team maps out communication touchpoints on an annual basis to provide members the information they need tied to key topics such as onboarding, personalized health reminders, cost savings opportunities, disease/case management outreach, and health and well-being engagement. The team leverages a variety of distribution channels to provide members information that is relevant to them in a timely manner and actionable format.

  Rating of the Specialist: In addition to the information received through the CAHPS survey, HealthPartners also surveys members who have received care in several key specialties (ex. Cardiology, ENT, ObGyn, Orthopedics, and Behavioral Health) to gain further insights into members' experience with specialty care. Results are shared with internal staff as well as contracted care groups where it can be used to enhance the experience for our members.

We have examined Quality of Care complaints specific to specialty providers, and have not seen a trend in specific providers with issues. We did note a number of complaints related to eye services, specifically cataract surgery; but no issues that generated any need for corrective action.

Our specialty network for Minnesota Senior Care Plus (MSC+) has been quite stable but we monitor for opportunities to add to the network based on need or increased demand for services. We monitor out of network requests for MSC+ patients and can use that to determine if there is an increased demand for alternative specialty providers.

Customer Service: Within Member Services, our customer service department, there are multiple avenues for member feedback to be received and responded to. Below are examples of the ways our Member Services team monitor and address member feedback.

- Calls are monitored (listened to and scored) on a monthly basis by Quality Assurance Analysts and by Supervisors. Listening to these calls is a touchpoint for leaders to hear directly from members in their own words. If any additional resolution steps are possible at the time of the monitoring, feedback and outreach is provided to the rep and/or the member.
- Member call trends are discussed weekly in huddles throughout Member Services. Representatives, Quality Assurance Analysts, and Leadership discuss what members are calling about that week and brainstorm ideas to help assist these members even better moving forward. These trends typically result in updated resources or talking points for our reps to refer to during phone calls.
  - Example of a call trend response: Members were asking for more information about when/where/how to get the COVID-19 vaccine. We worked together with our Care Groups to share information about patient vaccine availability and notification plans upon request. Waves of email communication were sent to members, and an upfront informational greeting was added to our Member Services phone line to give callers immediate COVID vaccine information upon calling.
  - Monthly automated reports are generated and reviewed showing the number of calls per category by product to identify which topics our members have more questions about over time. This helps the team focus process improvement efforts around the top drivers of member calls and member grievances.
  - We simplified the search process in HCSS, the system used by Member Services. This results in quicker results to share with members and increased satisfaction.
  - Improved Medicaid member care support in Northeast and Central Minnesota through in-person local resources through partnerships with community organizations.
  - We created a faster problem-solving process with internal partners to assure quicker resolution of member issues. For example, we now have an enhanced pharmacy “hand off” process in which our Member Rights and Benefits (Appeals) team works directly with Pharmacy Administration early in a potential appeal situation to resolve the issue before an appeal even begins.

- We have implemented post-chat surveys so members can give immediate feedback following an on-line chat.
- Member Services Performance Reports are regularly reviewed. This report shows results from Member Services call interactions that can point to trends in calls by reason type; for example, difficulty in finding a provider, issues in understanding benefits, etc.

Getting Needed Care & Getting Care Quickly: These measures focus on the members' ability to get the care they need and get care in a timely manner. Keeping in mind that many of our Medicaid members receive care from our own care group, HealthPartners monitors access to both primary care and specialty care through monthly Primary Care and Specialty Care Access Reports. These reports provide comparisons to previous months as well as identify specialties that meet, exceed, or fall short of our access goals.

Shared Decision Making: Care Coordinators for our SNBC members are trained to provide decision support to members. Care Coordinators receive an initial training during their onboarding and participate in annual refresher trainings thereafter. Some examples of the support that care coordinators provide or arrange for which can support shared decision-making and ensure that members understand their medication include:

- Arranging for a skilled nursing visit to provide medication education and set-up.
- Our SNBC care coordinators work closely with clinic care coordinators and hospital discharge planners to ensure that members understand their medications and post-discharge instructions. Clinic care coordinators ae trained to provide shared decision making in a clinic visit with the provider.

Both Regions and Methodist hospitals utilize Community Paramedics to provide home visits to patients following hospital discharge. They can perform vital exams, home safety assessments and assist with medication management.

To expand on our Medication Therapy Management (MTM) capabilities, HealthPartners network of MTM pharmacists work with individual members currently experiencing or who are at risk of experiencing medication related problems. It is complementary to the Disease and Case Management service and provides free, confidential one-on-one appointments with an experienced clinical pharmacist to help members get the results they need from their medications. Members and patients will leave the appointment knowing:

- They are taking the right medication to achieve their best health
- How to avoid problems, like side effects and interactions
- Ways to make your medicine better fit your lifestyle
- Ideas to cut costs on prescriptions

HealthPartners MTM is a highly valued program as seen in the results below:

- 97 percent would strongly recommend these services to friends and family
- 98 percent rate overall quality of care as "excellent", "very good" or "good"
- 96 percent feel more confident in managing their medicines after their visit

HENNEPIN HEALTH

- **2018 Recommendation:** 2018 Financial Withhold – Hennepin Health work to address measures that failed to meet target goals, routinely monitor the effectiveness of current improvement activities and modify them as needed.

  MCO Response: Hennepin Health work to address measures that failed to meet target goals, routinely monitor the effectiveness of current improvement activities and modify them as needed.

  F&C – MA and MNCare

  Hennepin Health did not achieve the 2018 financial withhold in the following performance measures:

  - Dental Service Utilization Rate for Children (ages 1-20 years)
  - Dental Service Utilization Rate for Adults (ages 21-64 years)
  - Dental Network Provider Equity
  - Hospital 30-Day Readmission Rate

  Dental Service Utilization Rate for Children and Adults

  Although Hennepin Health did not meet the dental service utilization rate withhold, Hennepin Health was the only MCO in Minnesota to increase dental utilization by more than 5% within the 1-20 age group in 2018. Hennepin Health was able to achieve a 6.66% utilization increase from 2017 for the 1-20 age group.

  For many years, Hennepin Health has focused on dental service utilization and access for both children and adults. As part of the Hennepin Health Medicaid Expansion Demonstration Project with DHS, a Dental Clinic was opened that serves both the Hennepin Healthcare Coordinated Care Clinic and the Hennepin Healthcare Access Clinic. The clinic is staffed by Advanced Dental Therapists, Dental Assistants, and a Dental Hygienist. The dental clinic only sees Hennepin Health adult members/ Members who require dental services that cannot be performed at this dental clinic are referred to the Hennepin Healthcare Clinic and Specialty Center Dental Clinic.

  Hennepin Health conducted a PMAP/MNCare Dental Utilization Focus Study during 2018 – 2019 which included a root cause and barrier analysis on member, provider and system drivers impacting dental utilization and access. To increase dental utilization and access, Hennepin Health implemented several interventions and strategies focused on member education, the importance of oral health care, and annual visits to a dental provider as well as support to assist members with accessing dental services. In collaboration with Northpoint Health and Wellness, Hennepin Health established two back-to-school clinic days in which children could receive both an annual well-child visit and dental visit in 2018. Children who completed both exams were given a backpack full of school supplies. Additional interventions that were implemented and are ongoing include:

- Providing education as appropriate to both internal and external staff on the importance of oral health and their role in assisting members.
- Informing members of the importance of preventive oral care through member events, mailings, and telephone messages.
- Informing members of the availability of dental benefits for adults and children through the Member Handbook and member website.
- Helping members schedule dental appointments, arranging transportation/interpreter services, providing reminder calls for the appointment, and follow-up services to assure the member made the appointment.
- Focus on families residing in areas predominantly populated by people of color to address racial oral health disparities.
- Implemented a dental incentive program with the use of $25.00 gift cards.
- Employing a Community Health Worker to contact members, arrange dental appointments and establish relationships with dental providers.
- Working with Hennepin Healthcare Dental Clinic to establish a dental therapist at Whittier Clinic three days per week to provide dental services to pediatric members.

Additional dental care coordination (DCC) is provided by a dedicated team of in-house DCCs at Delta Dental of Minnesota. Delta Dental will assist in finding nearby providers that can see the member in a timely manner, whether it is for emergency care or preventive care. The dental network includes 1,400 dentists with over 200 access points of bi-lingual providers, ADA accessible offices, exam rooms and equipment. In addition, the providers completed Cultural Competency Training within the past 12 months to meet the wide variety of member needs. If the Customer Service Representative (CSR) is unable to assist the member in finding a dental provider to meet their needs, the CSR will conduct a warm transfer to the DCC Team, introducing the DCC, and ensuring a smooth hand-off. The DCC gathers specific information regarding the member's special needs, preferences, and dental concerns. The DCC then offers a list of providers, individually tailored to the member's specific needs. Once an acceptable dental provider has been identified, the DCC initiates a conference call to the provider, moderating the scheduling process. Delta Dental always strives to find appointment times that are convenient for the member and their schedule. While discussing provider options, DCCs often advise on the approximate schedule of each provider's office, allowing the member to find the soonest appointment as close to home as possible. DCCs also always strive to schedule emergency or pain appointments within two days to reduce emergency room visits, and preventative care appointments within 60 days. The average appointment wait time to see a dentist in 2020 was less than 15 days.

Hennepin Health monitors dental utilization through dental utilization reports provided by Delta Dental on a monthly basis. Hennepin Health's strategies are continually monitored to ensure the program remains effective in continuing improvement of dental utilization and reducing racial

inequities. Hennepin Health will continue its efforts to improve utilization and access rates for pediatric dental visits.

Dental Network Provider Equity

Hennepin Health, in collaboration with Delta Dental, encourages dental providers to provide dental services to Medicaid fee-for-service (FFS) members in addition to Hennepin Health's PMAP/MNCare members. Some dental providers have chosen not to provide dental services to Medicaid FFS members due to capacity issues as well as Medicaid FFS dental reimbursement rates. Other dental providers, such as Hennepin Healthcare Dental Clinic, provides dental services to Medicaid FFS members, but Medicaid FFS members may not seek dental services at these dental providers. Hennepin Health reviews and monitors this rate when the DHS Withhold reports are sent to Hennepin Health as Hennepin Health does not have access to Medicaid FFS dental claims.

Hospital 30-Day Readmission Rate

Reducing the 30-day readmission rate has been a strategic focus point in the Hennepin Health's Population Health Management Program – Managing Outcomes Across Settings. The Homeless Readmissions Reduction Pilot for PMAP/MNCare members was launched February 2019 after a few months of planning and analysis in collaboration with Hennepin Healthcare leadership and inpatient teams. Social service and nursing care management launched the pilot with the goal of reducing all-cause PMAP/MNCare readmissions at Hennepin Healthcare. Data studied by Hennepin Healthcare showed that the Hennepin Health PMAP/MNCare members accounted for 16.7% of the readmissions which was 3% higher than the total patient readmission for all-payers at Hennepin Healthcare. Analysis of the readmission causative factors were determined to be substance use disorder (SUD) and housing instability.

A lean process was initiated, and a root cause analysis conducted. The pilot's hypothesis was "if the right staff are involved at the right time" it would lead to a decrease in readmissions in 2019, as a consistent and standard response for assisting homeless Hennepin Health members would be used. For the pilot, Hennepin Health Social Service Navigation staff met with eligible homeless members in the inpatient setting. The pilot program focus expanded to include eligible members living with substance use disorders in mid-2019. Addressing racial disparities was and will continue to be a component of pilot program. Data was monitored on a monthly basis throughout the pilot program. By year's end, only 5% of members involved in the pilot program were readmitted compared to 15% of other Hennepin health patients who did not participate in the pilot program. The pilot program officially ended December 31, 2019 and will continue as a standard care management process. The Hennepin Healthcare inpatient and Hennepin Health's social services continue to meet on a monthly basis. Readmission rates will continue to be monitored on a quarterly basis.

SNBC

Hennepin Health did not achieve full points for the SNBC annual dental visit, age group 19-64 years, as the target goal was not met. The Department of Human Services and the MCOs have identified that the annual dental visit utilization for SNBC members is low and is a state-wide issue. In response to this effort, the MCO Collaborative SNBC Dental Access Improvement Project was initiated in 2016 and ended on December 31, 2019. This project includes both member and provider initiatives. Hennepin Health participated in this collaborative along with Medica, PrimeWest Health, South Country Health Alliance and UCare.

Through the Collaborative, numerous best practices were noted throughout the project and added to the overall success of the project. Highlights included:

- The collaborative partnership between the MCO's and DHS staff was vital to the ongoing success of this project. Open communication throughout the project enabled the MCO's to react to feedback from surveys and stakeholders, while continuing to move forward with the goal of increasing access.
- Gaining insight from experts in the oral health field was a key component to the project. The Expert Panel brought information about the current state of the field, best clinical practices and direct knowledge of the barriers in serving the special needs population.
- This project included a wide variety of interventions, including work with members, case managers and the provider community. Critical to the project was the wide cross section of stakeholders involved. From the MCO's, representation included expertise in oral health, case management and quality improvement. Each area of expertise brought a unique lens to the project, which only helped to strengthen the interventions.

Although reimbursement rates and benefit set were not within the scope of the project, the role of reimbursement and the limited adult dental benefit set plays a significant role in dental access and utilization. These topics were frequently raised by community partners, dental providers, care coordinators and counties throughout the length of the SNBC Dental Access Improvement Project and continues to be areas of concern.

Both member and provider surveys were conducted to identify opportunities for improvement for improving dental access and utilization. For SNBC members who did obtain dental services, 97 percent of the respondents indicated that they had seen a dentist within the last 12 months with 85 percent stating they had a regular dentist. SNBC members who did not utilize the dental services identified the following reasons for not seeing the dentist:

- Thirty-six percent tried but could not get an appointment when needed.
- Twenty-two percent reported that they could not find a dental office that could work with their physical or mobility limitations.

- Forty-six percent reported they did not see a dentist due to a previous bad experience and 33 percent were afraid to visit a dentist.
- Fifty-seven percent of members reported they were concerned about having to pay for non-covered dental services and that reason kept them from seeing a dentist.

Common theses which emerged through the providers survey were:

- Unwilling to see new Medicaid patients due to inadequate reimbursement and limited benefit set;
- The lack of coverage for periodontal services and the restrictive sedation benefits are barriers to appropriate care.

In collaboration with the MCOs involved in the SNBC Dental Access Improvement Project, intervention strategies were developed to improve dental access for all members. The following activities were conducted for this collaborative project.

Members

- Conducted outbound telephone calls by care coordinators to inform members about the availability of their dental benefits and provided assistance in finding a dentist, arranging an appointment and/or arranging transportation and interpreter services, as needed.
- Distributed Tips for Good Oral Health brochure to members by care coordinators.
- Mailed Dental Outreach Letters to members if the care coordinators could not reach the members.
- Provided education on the importance of dental care and annual dental visits to members by care coordinators when conducting the health risk assessment and care planning process.
- Educated care coordinators on the importance of scheduling annual dental exams for members. Care coordinators were also educated on how to use Delta Dental to assist in scheduling of exam.
- Contacted members who had not had a dental visit within the last 12 months and members new to SNBC by care coordinators to inform members about the availability of their dental benefits and provided assistance in finding a dentist, arranging an appointment and/or arranging transportation and interpreter services, as needed.
- Mailed Dental Outreach Letters and conducted outbound telephone calls to members who refused care coordination by Hennepin Health staff.
- Providers and Care Coordinators
- Developed a provider tool on how to work effectively with the special needs population in relation to their dental care.
- Provided continuing education on oral health to care coordinators.
- Created a Mentoring Program to identify expert in the dental arena serviced the Medicaid populations with disabilities. They provided additional education to other Minnesota dental

providers serving Medicaid populations with disabilities on providing dental care to the members with disabilities.

- Collaborated with Direct Care &Treatment (DCT) to discuss barriers and areas of concerns. Gaps in knowledge about MCOs, dental delegates and dental benefits for patients served by these clinics were identified and addressed. Presentations at dental conference and other dental avenues to educate dental staff and providers were conducted.
- Developed and distributed a MCO 1010 Medicaid Dental Grid;
- Developed the Care Coordination Information Guide.

Hennepin Health encourages primary care providers to stress to their patients the importance of having an annual dental visit. This has been communicated through the Hennepin Health provider website, including the provider bulletin. Hennepin Health collaborates closely with Delta Dental, the dental vendor, on improving network access for adult members and to assist members in finding a dentist, when requested.

Hennepin Health will continue to monitor utilization rates on a quarterly basis. Hennepin Health evaluates and revises, as appropriate, the effectiveness of its interventions annually, at a minimum. Due to COVID-19 pandemic in 2020, dental utilization has decreased significantly as dental offices were closed for about 3 months in 2020. With the reopening of dental offices, dental offices have reduced the number of patients seen in a day in order to meet the COVID-19 CDC dental office practice requirements. Hennepin Health continues to work on improving access and utilization of dental services for the SNBC members, encouraging them to have an annual dental visit, which can lead to better overall health for the member. A monetary incentive in the form of a gift card was implemented in 2017 which a member can receive after completing a dental visit. Hennepin Health promotes the dental incentive and encourages the members to seek dental care through information on the members website and quarterly member newsletters, offering assistance in finding a dentist and providing transportation and/or interpreter services as needed. Encouraging and supporting the members' behavior change to seek dental care is an ever-ongoing process. This withhold measure will be an ongoing present focus for Hennepin Health.

- **2018 Recommendation:** HEDIS (Quality of Care) –
  - Hennepin Health should continue with the enhanced intervention strategy outlined in the Health Plan's response to the previous year's recommendation, routinely monitor the effectiveness of the strategy and modify it as needed.
  - Hennepin Health should leverage its relationship with county case managers and delegated care guide agency staff to reconnect with members.

MCO Response: Hennepin Health has an opportunity for improvement in the following areas of care:

F&C-MA

- Breast Cancer Screening
- Comprehensive Diabetes Care – Eye Exam
- Comprehensive Diabetes Care – HbA1c Testing
- Well-Child Visits in the First 15 Months of Life

MNCare

- Annual Dental Visit
- Controlling High Blood Pressure

Hennepin Health analyzes the HEDIS results annually and identifies measures which not only provide opportunities for improvement, but which are clinical priorities for our members and our accountable health model partners – Hennepin Healthcare System (HHS), NorthPoint Health and Wellness Center and Hennepin County Public Health and Human Services. Root cause analysis is conducted with strategical interventions developed and implemented, as appropriate, for the identified priority measures. Hennepin Health has implemented several strategies during 2018 -2020 to impact low-performing HEDIS rates. This includes strategies for both the provider and member.

Medicaid Expansion members comprise a high percentage (60%) of the Hennepin Health membership. A high percentage of these members are living with a mental illness and/or substance use disorders. Many members are faced with food insecurity, housing insecurity, unemployment, and are involved in the criminal justice system. Their focus is day-to-day survival, thinking only of the present day and what their needs are in that moment. The future is not something in the forefront of their thoughts; thus, the lack of long term thinking is a major barrier to members seeking out primary/preventive health services which is supported by Hennepin Health's HEDIS preventive services visit utilization rate. Medicaid Expansion members generally seeks acute episodic care and do not focus on preventive care needs.

F&C – MA Breast Cancer Screening

Hennepin Health continues to focus on improving the breast cancer screening rates. Hennepin Health monitors mammogram screening on a quarterly basis, in addition, to reviewing the annual HEDIS data. Interventions are evaluated for their effectiveness and are revised, as appropriate.

Hennepin Health encourages the primary care physicians (PCPs) to stress to their patients the importance of having a mammogram. This has been communicated through the Hennepin Health provider website and provider bulletin. The best opportunity for Hennepin Health to address breast cancer screening is to encourage members to seek preventive health care services and establish a primary care relationship. Hennepin Health continues to work with its providers on strategies to increase preventive health visits as well as encouraging members to receive the age-appropriate cancer screenings, such as mammograms.

Hennepin Health employs various communication avenues to encourage members to establish a medical home and receive age-appropriate cancer screenings. In addition to mailings and telephonic

outreach, Hennepin Health promotes mammograms through the quarterly member newsletter. Hennepin Health, in collaboration with Healthwise®, promotes the use of Healthwise® Knowledgebase, a health topics and health decision tool on the Hennepin Health member website through the quarterly member newsletter. Healthwise® Knowledgebase has easy to understand information about health conditions and preventive screenings in both English and Spanish. Hennepin Health implemented a member breast cancer screening incentive, effective the 4th quarter 2019 which continues. Postcards were mailed to eligible members who had not received a mammogram in 2019 informing them of the gift card incentive. The mammogram incentive voucher is posted on the Hennepin Health website. Through completion of the New Enrollee Screening survey, members may request information about mammograms and the mammogram cancer screening voucher.

F&C– MA Comprehensive Diabetes Care – Eye Exam

Hennepin Health continues to focus on diabetes care for the members who are living with diabetes. This focus includes encouraging members to receive a dilated retinal eye exam annually. Hennepin Health monitors eye exams rates for members living with diabetes on a quarterly basis, in addition, to reviewing the annual HEDIS data. Interventions are evaluated for their effectiveness and are revised, as appropriate.

Hennepin Health collaborates with HHS and NorthPoint providers in the development of strategies to improve the health for those living with diabetes. Through Hennepin Health Provider website, provider education is offered on the importance of encouraging members to have an annual eye exam. Hennepin Health and HHS are currently exploring the possibility of primary care practitioners (PCPs) conducting retinal scans using portable retinal scanners as, currently, eye exams are conducted only at the downtown Minneapolis Clinic and Specialty Center. This is a potential barrier for members receiving their care at a community clinic location as members may not want to go to the downtown location for their eye exam.

Various communication avenues are used to encourage members living with diabetes to get a dilated retinal eye exam. Hennepin Health informs members about the importance of getting an eye exam through the quarterly member newsletter. As described above, Hennepin Health, in collaboration with Healthwise ®, promotes the use of Healthwise ® Knowledgebase, a health topics and health decision tool on the Hennepin Health member website. Members are informed about Healthwise ® Knowledgebase in the quarterly member newsletters and are encouraged to use this tool. Hennepin Health implemented an incentive for dilated retinal eye exam, effective the 4th quarter 2019 which continues. Postcards were mailed to eligible members living with diabetes who had not received an eye exam in 2019 informing them of the gift card incentive. The eye exam incentive voucher is posted on the Hennepin Health website. Through completion of the New Enrollee Screening survey, members may request information about diabetes and the eye exam voucher.

F&C-MA Comprehensive Diabetes Care – HbA1c Testing

Hennepin Health's focus on diabetes care for the members who are living with diabetes includes encouraging members to get an HbA1c test at least annually. Hennepin Health monitors HbA1c testing rates for members living with diabetes on a quarterly basis, in addition, to reviewing the annual HEDIS data. Interventions are evaluated for their effectiveness and are revised, as appropriate.

Hennepin Health collaborates with HHS and NorthPoint providers in the development of strategies to improve the health for those living with diabetes. Through Hennepin Health Provider website, provider education is offered on the importance of encouraging members to have receive annual diabetes care which includes HbA1c testing.

Various communication avenues are used to encourage members living with diabetes to establish a medical home and seek care for their diabetes at least on an annual basis. Hennepin Health informs members about the importance of seeing their PCPs at least annually for preventive care and for care of any chronic condition, such as diabetes, through the quarterly member newsletter. Members are also encouraged to monitor their glucoses daily at home and to attend diabetic education classes. As described in the previous section, Hennepin Health, promotes the use of Healthwise ® Knowledgebase which is on the Hennepin Health member website. Members are informed about Healthwise ® Knowledgebase in the quarterly member newsletters and are encouraged to use this tool. Hennepin Health implemented an incentive for an annual HbA1c test, which started in the 4th quarter 2019 and continues in 2021. Postcards were mailed to eligible members living with diabetes who had not seen a PCP in 2019 informing them of the HbA1c gift card incentive. This incentive voucher is posted on the Hennepin Health website. Through completion of the New Enrollee Screening survey, members may request information about diabetes and the HbA1c incentive voucher.

F&C-MA Well-Child Visits in the First 15 Months of Life

Since 2016, when Hennepin Health was awarded a F&C/MNCare contract from DHS, Hennepin Health has implemented a comprehensive strategy to promote and improve completion of the recommended infant well-child visits – 6 visits before 15 months of age. This includes an incentive rewards program that offers a $75.00 gift card to the parent if their infant completes the 6 well-child visits before 15 months of age. The voucher is present on the Hennepin Health website under the rewards program section. In 2019, Hennepin Health developed a New Mothers packet that is mailed to individuals shortly after delivery. The New Mothers packet provides information on postpartum care, depression, infant care and the well-child visits incentive voucher.

Hennepin Health monitors well-child visit rates on a quarterly basis, in addition, to reviewing the annual HEDIS data. Interventions are evaluated for their effectiveness and are revised, as appropriate. Hennepin Health conducted a focus study on well-child and adolescent visits in 2018 - 2019, identifying and addressing barriers to care which included lack of knowledge on the

importance of well-child visits, lack of access to transportation and unavailability of babysitters to care for the younger children. Using the HEDIS technical specifications, Hennepin Health determines member compliance with well-child visits through medical claims data and medical record review every year during HEDIS season. The five components of a well-child visit can be completed during the same officer or over multiple illness visits, as long as they are completed within the required time period. Common themes identified when completing the HEDIS chart reviews were:

- Many infants receive the first 5 well-child visits within the required timeframe; however, the last visit may not occur, or it may fall outside the required timeframe.
- Infants with acute or chronic conditions may be seen frequently by their PCP or by a pediatric specialist for follow-up, but certain required elements of the well-child visits such as anticipatory guidance is not a part of these visits.
- Many healthcare systems use a checklist embedded in the member's electronic medical record as evidence of compliance for anticipatory guidance. The checklist does not contain documentation of any education offered to the infant's parent; therefore, this is considered as not meeting the requirements. Through discussion with some providers, they were not aware that the checklist alone was insufficient and did not meet regulatory requirements.
- The well-child visit regulatory requirements were sent to providers via a provider bulletin, providing examples of what did or did not meet regulatory requirements. Information on the importance of well-child visits for infants and children is provided through the quarterly member newsletter, which is especially important during the COVID-19 pandemic. As described above, Hennepin Health promotes the use of Healthwise Knowledgebase® tool on the Hennepin Health member website through the member newsletter and encourages members to use the tool to review topics of interest for them. Through completion of the New Enrollee Screening survey, members may request information about pregnancy, infant care, car seats and the well-child vouchers.

Hennepin Health finds it valuable to work with other Minnesota MCOs and stakeholders in the implementation of PIPs which supports consistent provider practices and provider and member messages as a way to minimize consumer confusion, enhance member healthcare experiences, provide continuity of care, promote racial equity and eliminate duplication of services. For the 2021-2023 "Healthy Start" Performance Improvement Project (PIP), Hennepin Health is a participant in the MCO PIP Collaborative (known as "Collaborative) which includes: Blue Plus, HealthPartners, South Country Health Alliance, and UCare. Stratis Health provided guidance and support for the PIP.

The "Healthy Start" PIP is intended to promote a healthy start for PMAP/MNCare children by focusing on and improving services provided to pregnant people and infants, particularly in populations exhibiting racial and ethnic disparities. Hennepin Health will be supporting joint collaborative interventions in addition to the plan-specific strategies.

Hennepin Health will work with its accountable health model partners and other healthcare providers to address social determinants of health and barriers to care for pregnant people and children, ages 0 – 30 months, in order to improve pregnant people's overall health and provide children with a healthy start in life. Hennepin Health has established goals aimed at promoting racial equity and improving prenatal care, postpartum care, well-child visits, ages 0-30 months and Combo-10 immunization rates for children ages 0 – 30 months. Collaborative and Hennepin Health specific interventions focusing on improving the well-child visits rate include:

- Collaborative interventions
- Develop education, resources, and tools for care teams.
- Develop an education series for providers and other care team members addressing gaps in knowledge identified through research and networking with various stakeholders. Topics may include implicit bias, immunization education and effective utilization of telehealth.
- Collaboration with County Partnerships – Family Home Visiting Program is a core service of many Minnesota county public health agencies which uses evidence-based curriculum to support pregnant women and families with young children. Metro Action Group (MAG), which consist of County Public Health and metro health plans staff that provide Medicaid benefits to F&C - MA program from each of the seven metro counties, collaborates on child check-ups strategies, early childhood access to care, reducing disparities in pregnancy and child health outcomes. This group meets every other month to keep each other abreast of changes in both the county and health plans well-child visits programs. In addition, the group meets with the seven county metro area health care providers to provide education on the importance of well-child visits, discuss strategies to address barriers, inform providers about health plan well-child incentives, and other identified issues.
- Hennepin Health Specific Interventions
- Conduct member outreach to encourage well-child visits and immunizations.
- Continue member education through Healthwise® Knowledgebase and New Mothers packet.

MNCare Annual Dental Visit

Although Hennepin Health did not meet the dental service utilization rate withhold, Hennepin Health was the only MCO in Minnesota to increase dental utilization by more than 5% within the 1-20 age group in 2018. Hennepin Health was able to achieve a 6.66% utilization increase from 2017 for the 1-20 age group. Hennepin Health's MNCare population is relatively small; thus, the annual eligible population for the HEDIS Annual Dental Visit for children/teenagers ages 2-20 was 52 in 2018 and 38 in 2019, significantly lower than the required 411 sample size required by National Committee for Quality Assurance (NCQA). With this relatively small sample, the impact of a few children not having a dental visit significantly impacts the overall rate.

For many years, Hennepin Health has focused on dental service utilization and access for children. Hennepin Health conducted a PMAP/MNCare Dental Utilization Focus Study during 2018 – 2019 at

which time a root cause and barrier analysis on member, provider and system drivers impacting dental utilization and access was conducted. To increase dental utilization and access, Hennepin Health implemented several interventions and strategies focused on member education, the importance of oral health care, and annual visits to a dental provider as well as support to assist members with accessing dental services. The interventions that were implemented and are ongoing include:

- Providing education as appropriate to both internal and external providers on the importance of oral health and their role in assisting members.
- Informing members of the importance of preventive oral care through mailings and telephone messages.
- Informing members of the availability of dental benefits for children through the Member Handbook and member website.
- Focus on families residing in areas predominantly populated by people of color to address racial oral health disparities.
- Implemented a dental incentive program with the use of $25.00 gift cards.
- Employing a Community Health Worker (CHW) to contact members, arrange dental appointments and establish relationships with dental providers. The CHW also arranges transportation/interpreter services and provides reminder calls for the appointment.
- Working with Hennepin Healthcare Dental Clinic to establish a dental therapist at Whittier Clinic three days per week to provide dental services to pediatric members.
- In collaboration with Northpoint Health and Wellness, Hennepin Health established two back-to-school clinic days in which children could receive both an annual well-child visit and dental visit. Children who completed both exams were given a backpack full of school supplies.

Hennepin Health monitors dental utilization through dental utilization reports provided by Delta Dental on a monthly basis. Hennepin Health's strategies are continually monitored to ensure the program remains effective in continuing improvement of dental utilization and reducing racial inequities. Hennepin Health will continue its efforts to improve utilization and access rates for pediatric dental visits.

MNCare Controlling High Blood Pressure

Hennepin Health's MNCare population is relatively small; thus, the annual eligible population for the HEDIS Controlling High Blood Pressure (CBP) is about 150, which is significantly lower than the required 411 sample size required by National Committee for Quality Assurance (NCQA). Hennepin Health's MNCare HEDIS Controlling High Blood Pressure result was about 8 percent lower than the statewide average.

Various communication avenues are used to encourage members living with hypertension to see their PCP on a regular basis, monitor their blood pressure, and take their medications on a regular

basis. Hennepin Health encourages members to use the Healthwise ® Knowledgebase page on the member website to educate themselves on topics such as self-management of high blood pressure. Members are informed about Healthwise ® Knowledgebase in the quarterly member newsletters. Through completion of the New Enrollee Screening survey, members may request information about care management and controlling high blood pressure. Hennepin Health will continue to monitor the HEDIS CBP rates for this population. In addition, Hennepin Health monitors preventive care visit rates, including for members with the diagnosis of hypertension, on a quarterly basis.

- **2018 Recommendation:** CAHPS (Member Satisfaction) –
  - In regard to customer service, Hennepin Health should identify methods for capturing member feedback on the helpfulness of the Member Services Representative with whom the member made contact with. Hennepin Health should monitor Member Services calls for quality improvement.
  - Hennepin Health should reeducate members and providers on appointment timeframe standards.
  - If the addition of the Fairview Health System to the network demonstrates a positive impact, Hennepin Health should identify additional options for network expansion.

MCO Response: Hennepin Health has an opportunity for improvement in the following areas of care:

F&C-MA
- Getting Needed Care
- Customer Service
- Rating of All Health Care
- Rating of Specialist Seen Most Often
- Rating of Health Plan

MNCare
- Customer Service
- Shared Decision Making
- Rating of All Health Care
- Rating of Specialist Seen Most Often
- Rating of Health Plan

SNBC
- Getting Needed Care
- Customer Service
- Rating of Specialist Seen Most Often
- Rating of Health Plan

Hennepin Health's members' experience is of critical important to Hennepin Health. Hennepin Health monitors and uses the CAHPS survey results, grievances and appeals data and the provider survey results to identify areas in which Hennepin Health has an opportunity to improve. Taking into consideration the population characteristics, including social determinants of health, the community

and Hennepin Health's partners' resources as well as other survey results, strategies and activities are developed, implemented, evaluated and revised, as appropriate to address CAHPS scores. New in 2021, Hennepin Health will apply the Hennepin County's Racial Equity Impact Tool (REIT) with CAHPS strategy development to identify any possible unintended consequences and impact leading to increased racial disparities. This tool will be used annually.

Historically, Hennepin Health has had a 4-9 % lower response rate for the F&C-MA when compared to other health plans. Therefore, one should consider the potential for non-response bias when interpreting CAHPS results. Reaching Hennepin Health's members through the mail and telephone is challenging. Members move often and telephone numbers are disconnected or may have no or a filled voicemail. Hennepin Health uses various methods in the attempt to reach members. In addition to the mail and telephone, Hennepin Health will use members' email address, when available, or text the member with the member's consent. Hennepin Health has worked diligently to inform members about CAHPS survey and to encourage them to complete the survey. A CAHPS message is added to the Member Service call-waiting line with information is put on the plan's website, member newsletter, and social media. According to the 2020 Enrollee Fall Survey, members indicated that the preferred communication method is email with text messaging being the second most preferred method. Hennepin Health would be willing to collaborate with DHS and other health plans to explore other methods in conducting the CAHPS survey.

Shared Decision-Making – MNCare

Hennepin Health – MNCare does not have a sufficient population size to obtain an adequate sample for the CAHPS survey. Therefore, the Hennepin Health population is combined with other MNCare plans that do not have a sufficient population size to obtain an adequate survey sample size, including IMCare, PrimeWest Health (PW) and South Country Health Alliance (South Country), that are county based purchases providing services and benefits to Medicaid members residing in great Minnesota counties. The shared decision-making result is a combined rate of Hennepin Health, IMCare, PW and South Country. Hennepin Health is the only health plan providing services and benefits to Medicaid members located in Twin Cities area. This adds complexity in
Identifying the potential underlying drivers for scores as IMCare, PW and South Country MNCare population demographics and the needs of the members in greater Minnesota are different than the Hennepin Health MNCare populations demographics and needs of members in a metropolitan county.

Hennepin Health works with the network providers to identify key conditions that merit shared decision-making based on the potential to improve health outcomes and the value of care. Hennepin Health encourages provides to use shared-decision-making practices when providing care to Hennepin Health's members. In addition, Hennepin Health, in collaboration with Healthwise®, promotes the use of Healthwise® Knowledgebase, a health topics and health decision tool on the Hennepin Health member website. Healthwise® Knowledgebase has easy to understand information

about health conditions and preventive screenings in both English and Spanish. This tool provides information on how to engage in shared decision-making when discussing treatment options with their provider. Members are informed about Healthwise® Knowledgebase in the quarterly member newsletters and are encouraged to use this tool.

Member Satisfaction

F&C-MA, SNBC - Getting Needed Care, F&C-MA, MNCare - Rating of All Health Care; and F&C-MA, MNCare, SNBC - Rating of Specialist Seen Most Often

Hennepin Health conducts a root cause analysis to identify and address issues that are driving the CAHPS scores for the following: Getting Needed Care, Rating of All Health Care and Rating of Specialist Seen Most Often. Hennepin Health uses multiple reference points to track and ensure members have access to the services and care needed within the provider network such as:

- Soliciting feedback from the Hennepin Health accountable health model partners and other network providers.
- Obtaining feedback from members through the Enrollee Advisory Council and member surveys about the network.
- Reviewing the adequacy of the network, addressing identified issues quarterly by the Network Management and Provider Relations Collaborative workgroup.
- Analyzing grievance and appeal data quarterly.
- Reviewing services performed by non-contracted providers quarterly to identify contracting opportunities that would strengthen the network for Hennepin Health members.
- Conducting and reviewing the annual provider access and availability survey results. Hennepin Health conducted two provider access and availability surveys in 2019 to assess the adequacy of the network. The December 2019 survey again found adequate access and appointment availability to medical care for Hennepin Health members.
- Various strategical interventions have been implemented and include:
- Expanding the provider network in 2019 to include Fairview Health Systems for the Hennepin Health's F&C- MA/MNCare product.
- Contracting with additional specialty transportation companies to increase wheelchair and stretcher transportation options for members.
- Contracting with behavioral health providers to increase the number of the network contracted behavioral health providers.
- Educating members and providers about the acceptable appointment timeframe for health care visits through the website, member newsletter and in-person meetings with providers.
- In the fall of 2020, Hennepin Health conducted a member survey of PMAP/MNCare and SNBC members that included questions about satisfaction with benefits, providers and accessing services with the following results:
- When asked "What was the most important to you in choosing Hennepin Health as your health plan?", the top reasons were that their doctor accepts Hennepin Health (25%) and

the location being in downtown Minneapolis (18%). 26% of the respondents indicated that they did not choose Hennepin Health as their health plan.

- 72% of the respondents stated that they were extremely or somewhat satisfied with the options of doctors, dentists, clinics, hospitals and pharmacies they can choose for care. When asked what providers or health care systems members would like to see added to the network, many requested providers or health care systems Hennepin Health currently has in the network such as Fairview Health System.
- Of the members who used transportation services, bus cards or taxi rides to get to medical/dental appointment and/or the pharmacy, 82% (103 enrollees) were extremely or somewhat satisfied with their transportation service experience. When asked what advise they have to help improve member transportation services, no trend was identified.

Hennepin Health is continuing to evaluate the 2020 fall member survey results and will implement strategies to address the findings. The initial results indicate that an opportunity exists to educate members about current providers within the Hennepin Health network. Hennepin Health continues to explore adding providers to the network, as appropriate, based on data and information received to meet the needs of the members. Hennepin Health's strategies are continually monitored and revised, as needed, to ensure the Hennepin Health network meets the needs of our members.

F&C-MA, MNCare, SNBC - Customer Service, F&C-MA, MNCare, SNBC - Rating of Health Plan

There are three components which contribute the Rating of Health Plan composite score – member materials, customer service and members receiving the care they need. Member satisfaction of their health plan, health care and getting needed care is influenced by the providers' satisfaction with the health plan. Hennepin Health has a dedicated Member Service and Provider Service teams to answer incoming calls with the goal of resolving concerns with one call.

Hennepin Health conducted a root cause analysis to identify the issues which may be contributing to the CAHPS Customer Service score and the Rating of the Health plan. Other information used to identify and address issues impacting the Customer Service and Rating of Health Plan rates include, but it not limited to:

- Review of real-time and quarterly grievance and appeal data.
- Offering a Customer Service post-call survey to members and providers for immediate collection of feedback.
- Implementing live monitoring auditing of live calls between the member or provider and the Customer Service Department Representative.
- Obtaining feedback from members through the Enrollee Advisory Council and member surveys about the network.
- Reviewing the adequacy of the network, addressing identified issues quarterly by the Network Management and Provider Relations Collaborative workgroup.

- Assigning a Provider Service representative to a large care system as a liaison to focus on resolving inquiring and tracking and trending issues at the account level, with a proactive and planning perspective. Meetings are held at least quarterly.
- Engaging the Enrollee Advisory Council to review and provide information about member materials.
- Conducted member focus groups and telephonic survey in 2019 to gain a better understanding of the member's perspective of Hennepin Health as well as the services and benefits provided.
- Conducted a 2020 member fall survey that included questions about satisfaction with benefits, adequacy of Hennepin Health's provider network, and accessing services.

Post-call Customer Service survey results are reported by individual Customer Service staff, giving the opportunity for the Customer Service Auditor and individual staff to listen to the call. Additional training is provided as appropriate. The Member Services post-call survey results in 2019 and 2020 showed that overall members were satisfied with the overall service they received, rating their experience as a "5" about 90% of the time. Less than 1% of the members who responded to the survey rated their overall satisfaction as a "1" or "2". A high percentage (94 – 98%) of members give Customer Service staff a "5" rating for being knowledgeable about their inquiry and courteous and respectful. Many members leave positive comments about their Customer Service experience in the post-call survey.

Please see the above sections for the results of the 2020 Member Fall Survey. The 2020 Member Fall Survey results are currently being reviewed and will be used to tailor benefits and other services as a way to meet the identified member needs.

Some strategies implemented based on the information received include, but are not limited to:

- Reduced the number of medical appointments per month in order to receive a bus pass.
- Promoting the use of Healthwise® Knowledgebase on the member website through member newsletter.
- Based on the feedback obtained through the focus groups and telephonic survey, redesigned the member website and the quarterly member newsletter.
- Implemented various remediation strategies to address increased hold-time when calling

Member Services in the fall of 2019 which was identified through analysis of real-time grievance data included:

- Cross training Provider Services staff to answer member calls.
- Adjusting staff breaks and lunchtimes to ensure optimal call coverage.
- Added temporary staff.
- Evaluated and revised standard work processes to reduce calls times.
- Implemented a new call center process in which member phone calls automatically roll-over to Provider Services representatives when the hold time reached a specific metric.

Hennepin Health will continue to monitor and review the data as identified above to trends and actionable items at least quarterly. Interventions will be implemented, evaluated for effectiveness and revised as appropriate.

- **2018 Recommendation:** 2018 Financial Withhold **–**
  - In regard to dental care, IMCare should continue with the improvement strategy described in the Health Plan's response to the previous year's recommendation. IMCare should routinely evaluate the effectiveness of each intervention and modify them as needed.
  - IMCare should develop a robust strategy aimed at decreasing hospital admissions.

MCO Response: Dental Care Withhold - IMCare continues to offer enrollees a robust dental network, offering enhanced payment rates above what the MA Fee Schedule offers providers. This is to ensure dental access for IMCare enrollees. IMCare implemented an Integrated Care System Partnership (ICSP) around the dental utilization withhold measure, if the desired withhold measure increases are obtained withhold recovery would be forwarded to the at-risk dental provider group. IMCare stays in close communication with IMCare dental providers through biannual Dental Committee Meetings as well as ongoing email communication. Additionally, IMCare offers assistance with scheduling dental visits and/or coordinating dental care upon request either on the initial enrollee screening or direct contact to IMCare. IMCare offers both provider and enrollee education on transportation available. Annually IMCare completes provider availability and network adequacy evaluation for all providers including Dentists. At the last evaluation, each enrollee was determined to have a dental provider within 60 miles of their residence and all dentists indicated that they could offer routine appointments within 60 days and urgent appointments within 48 hours. IMCare recently added an additional Dental Provider in a county that neighbors Itasca, enrollees may access care there with no authorization. To date, IMCare has had no Quality of Care grievances related to dental access to date. As noted above dental access efforts and interventions are ongoing. IMCare hopes to see an increase in dental utilization and meet withhold goals, however, anticipates some decrease in utilization during 2020 due to the closure of dental offices during the Covid-19 Pandemic and offices currently spacing appointment times to allow for appropriate sanitation between patients. IMCare evaluates the access to care daily through enrollee contacts, and on an annual basis through both network adequacy and provider availability reports, as well as the ICSP and Utilization Management Program Evaluation.

Hospital Admissions

IMCare has recently increased efforts to revise the Complex Case Management (CCM) Program which focuses on addressing enrollees at high-risk for admission or readmissions, through various referral streams. IMCare has offered additional training for CCM staff and providers will be notified of services available to plan enrollees. The Population Health Management (PHM) program goals include connecting with outpatient preventative care services that should reduce the risk for acute events requiring hospitalization. Individual outreach is conducted for those identified as high-risk for admission in hopes to connect them with the most appropriate and cost-effective care. IMCare plans to continue ongoing CCM/PHM interventions in hopes of reducing costs and connecting

enrollees with the most appropriate levels of care. The effectiveness of the programs will be determined through the annual Special Health Care Needs, PHM Reports as well as in the annual Quality Program Evaluation.

- **2018 Recommendation:** HEDIS (Quality of Care) –
  - As IMCare continues to demonstrate an opportunity for improvement in regard to women's health, IMCare should evaluate the effectiveness of its current improvement strategy. Member education on the importance of preventive screenings should be conducted using a multifaceted approach. Additionally, the improvement strategy should be enhanced to include provider-level interventions.

MCO Response: Women's Health - IMCare aims to improve utilization of preventative health services among all populations, including women. The Population Health Management Program focuses on offering information on preventative health services for women on both the IMCare Website IMCare.org as well as in the biannual enrollee newsletters. Additionally, IMCare has an ongoing Prenatal Initiative Focus Study which is meant to connect pregnant women with additional resources through Itasca County Public Health, to reduce risk of adverse events during the prenatal or post-partum period. Most recently IMCare started individual outreach to women with a pregnancy diagnosis on a claim in the previous month to offer education regarding the Prenatal Initiative Focus Study to ensure that they are aware of the resources available to them. In the most recent Practice Guidelines IMCare adopted evidence-based guidelines that support regular breast cancer screening as well as preventative health screening for adults. Practice Guidelines are disseminated to both providers and enrollees through biannual newsletters. Evaluation of effectiveness of these interventions will be discussed in the annual Quality Program Evaluation.

- **2018 Recommendation:** CAHPS (Member Satisfaction) **–**
  - IMCare should conduct root cause analysis and implement interventions to address identified barriers in the CAHPS. The MCO should also evaluate the effectiveness of existing interventions and update and modify them as needed.

MCO Response: CAHPS (Member Satisfaction) - IMCare, a county-based health plan, places high value on ensuring that enrollees are satisfied with the care and services they receive while on IMCare. IMCare employs staff who live and work in the community that IMCare serves. This incentivizes staff to offer an enhanced level of customer service to both enrollees and providers. IMCare has retained customer service staff over recent years and invested time in training both internal representatives as well as staff that address after-hours calls. IMCare distributed results of CAHPS surveys at the Provider Advisory Committee as well as through Provider Newsletter. IMCare also explains CAHPS results and the purpose of the survey in the enrollee newsletter to attempt to increase participation. IMCare did see year-to-year increases from 2019 to 2020 in Rating of Health Plan and Health Plan Customer Service measures for the PMAP population. MSC+ and MNCare measures were combined with other health plans due to the small sample size, so it is difficult to

determine whether measures that have improved are representative of IMCare enrollees or other plans. IMCare hopes to see continuous year-to-year improvements in the CAHPS survey. IMCare evaluates ways to improve enrollee experience on an ongoing basis and reports on it at least annually through the Quality Program Evaluation.

MEDICA

- **2018 Recommendation:** 2018 Financial Withhold – Medica should continue the dental care improvement strategy described in the Health Plan's response to the previous year's recommendation. Medica should routinely measure the effectiveness of the interventions and modify them as needed.

  MCO Response: Medica continues the focus on dental access as a priority for our members. Members who have been identified as having a gap in dental care in the past 12 months receive a gaps in care mailing encouraging them to utilize their Medica benefits and schedule a dental appointment. Resources are provided to assist members in locating a dental home.

  Medica continues to provide care coordinators quarterly gap in care lists that identify MSHO, MSC+ and SNBC members who had a gap in an annual dental visit. Care Coordinators are equipped to educate members about the importance of regular preventive dental care, and addresses any barriers the member may be experiencing. Care Coordinators are trained to utilize Medica's Dental Benefits Manager (Delta Dental) to assist members to find a provider and to secure an appointment if that level of help is needed.

  In addition to Care Coordinator outreach, Medica has leveraged the expertise and resources of Delta Dental to provide telephonic outreach to MSHO members who had a gap in care for dental services. A dedicated team at Delta Dental then assists members to find a dental home and schedule a dental exam. Medica has extended this initiative to SNBC members as well, focusing on assisting members in finding a dentist and scheduling an appointment.

  Medica regularly measures effectiveness of interventions through use of a QlikView dashboard. Dental Visit encounter data is brought into the dashboard, which allows Medica staff to evaluate results at the product level, broken down by setting (institutional/community), race and gender. Interventions are reviewed with a core team of leaders in the Medicaid segment and modifications are made based on results.

- **2018 Recommendation:** HEDIS (Quality of Care) – As women's health continues to be an opportunity for improvement for Medica, Medica's Quality Improvement Program should increase its member and provider education and outreach efforts.

  MCO Response: Medica has continued our focus on improvement of HEDIS performance on preventive care and chronic condition measures. Activities implemented in 2019 included a wide range of interventions focused on member outreach and education, provider outreach and closing gaps in care.

  Member focused interventions include articles in member newsletters about the importance of preventive care and cancer screenings. In addition, in 2019 the Quality Improvement team

completed four internal outreach initiatives aimed at closing gaps including: a breast cancer screening mailing, a spring gaps in care mailing, a fall gaps in care mailing, and calls to address medication adherence compliance.

Medica values the relationship members have with their primary care provider, and strives to ensure providers have gaps in care information that can be used during their member appointments. Interventions to support providers in helping to close gaps in care include producing gaps in care reports for care systems on a quarterly basis.

In addition, Medica has worked to improve our internal dashboards which help us continually monitor results and conduct internal analysis. In 2019, Medica incorporated an enhanced attribution model into dashboards for more accurate gap reporting and analysis.

We also continue our longstanding partnership with The American Cancer Society, who presented to Medica Care Coordinators about cancer screening in June 2019 providing resources and education that Care Coordinators use in their discussions with members.

- **2018 Recommendation:** CAHPS (Member Satisfaction) – Medica's CAHPS Committee should conduct root cause analysis and implement interventions to address identified barriers. The MCO should also evaluate the effectiveness of existing interventions and update and modify them as needed.

  MCO Response: Member satisfaction and CAHPS results continued to be a focus area for Medica. The Quality Improvement Work plan included CAHPS members' satisfaction goals and interventions in both 2019 and 2020. In 2019, Medica completed a CAHPS proxy survey so that Quality Improvement and Government Programs staff could identify trends and areas for improvement related to member feedback obtained. Government Programs staff, including representatives from Medicaid Leadership participate in CAHPS/HOS workgroup, identifying interventions and outreach work that can be done to improve satisfaction. The Quality Improvement team partners with the Marketing and Communications team to review results and identify opportunities for member outreach.

  Key activities implemented in 2019 include: Develop and implement a package of communication materials including a member letter, website banner, call hold script and social media post encouraging the completion of the CAHPS survey, should a member receive one. In addition, the team implemented a Spring gaps in care mailer, with new sections to reinforce questions about physical health, mental health, bladder control, and falls.

  In addition, Medica conducts its own annual survey of MSHO and SNBC members, specifically seeking feedback on Care Coordination. Every member enrolled in the Medica MSHO and SNBC plan is offered a Medica Care Coordinator. In addition to our internal team of Medica Care Coordinators,

Medica also contracts with Care Systems, Agencies, and Counties throughout Minnesota to provide Care Coordination for Medica members.

PRIMEWEST HEALTH

- **2018 Recommendation:** 2018 Financial Withhold –
  - Dental care: PrimeWest Health should continue with the quality improvement strategy described in the Health Plan's response to the previous year's recommendation [refer to page 144]. However, PrimeWest Health should investigate dental measures to determine why they remain flat despite the robust improvement strategy.
  - Hospital admissions and readmissions: PrimeWest Health should conduct root cause analysis, implement interventions based on identified barriers, and routinely monitor the effectiveness of improvement activities.

MCO Response: IPRO recommends PrimeWest Health continue our dental quality improvement strategies as outlined in the prior year's response. In addition, IPRO recommends PrimeWest Health complete an analysis to determine why rates are not showing more improvement despite our efforts. While PrimeWest Health did not meet the withhold goals for Annual Dental Visit (ADV), we have seen improvement in our ADV rate as reported by Healthcare Effectiveness Data and Information Set (HEDIS®). All age groups saw increases from 2019 to 2020, with an overall rate increase from 55.32 percent to 58.22 percent in the Families and Children population. As we analyze why rates have not shown more improvement, we have discussed the following:

PrimeWest Health sometimes finds it challenging to reach and engage with certain dentists or dental practitioners directly, which has created a challenge with dental provider recruitment.

Members have expressed concerns about the difficulty of traveling to a dental appointment or taking time off work for an appointment, especially if it is for a preventive dental service.

Members may have a lack of knowledge and acceptance of the importance of oral health care, especially preventive oral health care. This barrier also has a cultural component.

Members report having a fear of the dentist or dental anxiety and will only see a dentist when they are in pain. This barrier creates stress on the dental provider network due to the urgency with which members may then seek dental care when they are in pain.

There may be some data limitations related to the ADV withhold specifications. It is unclear if visits by a dental therapist count, and any services, such as fluoride varnish application, that take place outside of an office setting do not count. In rural areas, these sorts of visits are more common and may not be reflected in the rates.

In order to address these barriers, PrimeWest Health continues to implement the interventions that were mentioned in the previous ATR response, and we are also working to develop the interventions listed in the following. Note that some of these interventions were implemented much

more recently than the data reflected in the 2018 ATR, so it may be several cycles before improvements from these activities can be seen.

Since 2007, PrimeWest Health has awarded more than $2.5 million in grants to dental providers in our 13-county service area for projects designed to improve access to and the delivery of oral health services to our members. Community Reinvestment Grants made by PrimeWest Health to increase access to dental care for our members most recently include the following:

i. Apple Tree Dental: $25,000. Awarded in 2020, this grant was for helping build a new clinic in Fergus Falls to expand dental access for PrimeWest Health Minnesota Health Care Programs (MHCP) members in Big Stone, Douglas, Grant, Pope, Stevens, and Traverse counties.
ii. Caring Hands Dental Clinic: $3,000. Awarded in 2020, this grant was for the purchase of Personal Protective Equipment (PPE) during the COVID-19 pandemic to more safely serve our members in Big Stone, Douglas, Grant, Pope, Stevens, and Traverse counties.
iii. Caring Hands Dental Clinic: $276,000. Awarded in 2020, this grant was to expand access to dental care in Pipestone County to serve Medical Assistance (Medicaid) and Special Needs BasicCare (SNBC) members in the southwest region of Minnesota. Preventive services and a full scope of restorative services will be available.
iv. Family & Cosmetic Dentistry: $3,000. Awarded in 2020, this grant was for the purchase of PPE during the COVID-19 pandemic to more safely serve our members in McLeod, Meeker, and Renville counties.
v. Family & Cosmetic Gentle Dentistry: $3,000. Awarded in 2020, this grant was for the purchase of PPE during the COVID-19 pandemic to more safely serve our members in Douglas, Grant, and Pope counties.
vi. Mississippi Headwaters Area Dental Health Center: $3,000. Awarded in 2020, this grant was for the purchase of PPE during the COVID-19 pandemic to more safely serve our members in Beltrami, Clearwater, and Hubbard counties.
vii. St. Joseph's Community Dental Clinic: $3,000. Awarded in 2020, this grant was for the purchase of PPE during the COVID-19 pandemic to more safely serve our members in Beltrami, Clearwater, and Hubbard counties.
viii. St. Joseph's Community Dental Clinic: $250,000. Awarded in 2018, this grant is intended to fund a larger facility that accommodates more dental providers to serve more members in Beltrami, Clearwater, and Hubbard counties.

Dental voucher

Beginning in 2021, PrimeWest Health implemented a gift card voucher as an incentive for PrimeWest Health Families and Children and MinnesotaCare members to have a dental visit. PrimeWest Health will promote this voucher incentive with our local county partners, Head Start organizations, and other community partners such as the Early Childhood Dental Network (ECDN) to extend awareness of this incentive. The dental voucher will allow PrimeWest Health to place an additional focus on our Families and Children and MinnesotaCare members ages 1 – 64 who do not

have a dental home and who have not had any dental visits in the last 12 months. PrimeWest Health will also collaborate with dental providers to utilize the dental voucher incentive for PrimeWest Health patients of record who have not had a dental visit in the previous 12 months.

Addressing cultural barriers/oral health disparities and oral health equity

i. As PrimeWest Health has identified that cultural barriers may exist within our American Indian communities, we are taking steps to better understand these barriers and ways to overcome them. PrimeWest Health has hired a designated American Indian Relations & Population Health Coordinator who is responsible for serving as PrimeWest Health's lead American Indian relations coordinator. This includes facilitating relationships with relevant tribal entities as well as other entities involved in the health and welfare of Minnesota American Indian populations. The coordinator will assist in the development and implementation of PrimeWest Health strategies, programs, and products to improve the health care experience of American Indian members at an individual level, population health, health equity, and cost-effectiveness of health care delivery to American Indians. This includes oral health.

ii. PrimeWest Health is seeking to collaborate with Northern Dental Access Center on outreach efforts to better engage their American Indian patient population, using the dental voucher incentive as a strategy. Thirty percent of Northern Dental Access Center's patients identify themselves as American Indians. Patients of record without a dental visit in the last 12 months who meet the criteria of the dental voucher will be reminded of the incentive when they are contacted by Northern Dental Access Center to schedule their overdue dental visit. PrimeWest Health is also seeking to collaborate with Northern Dental Access Center to expand and strengthen the impact of their Community Health Workers (CHWs) to reduce cultural and economic disparities in oral health.

iii. The expected outcome of these interventions is to increase our ADV rate and the results of the interventions will be monitored through the ADV dental withhold rate, the HEDIS ADV rate, and qualitative feedback from our dental providers and stakeholders within our communities.

IPRO recommends completing a root cause analysis related to PrimeWest Health's hospital admissions and readmissions, implementing interventions, and monitoring them regularly for effectiveness.

PrimeWest Health monitors hospital admissions and readmissions through multiple avenues including review with our internal Utilization Management Committee and our Quality and Care Coordination Committee (QCCC). These groups assist with developing interventions and giving feedback on modifications. Additionally, PrimeWest Health partners with specific clinics through our value-based agreements. This initiative is called Accountable Rural Community Health (ARCH). Clinics that are a part of these agreements work on preventing readmissions and have quality

outcomes monitored as part of their contracts. Medication Reconciliation Post-Discharge (MRP) is an outcome measure that has been utilized.

In conducting root cause analysis, a major factor in hospital readmissions has been found to be medication errors. PrimeWest Health has had a focus over the years related to this topic via our MRP Project. To promote additional medication reconciliations, PrimeWest Health made the decision to reimburse providers who submit the CPTII 1111F code along with a form documenting their credentials. To qualify for reimbursement, the provider must be a registered nurse (RN) or other prescribing practitioner and must perform the medication reconciliation face-to-face with the member within four days of hospital discharge.

In examining the effectiveness of the MRP intervention, it was found that members who received medication reconciliation were less likely to experience a readmission than those who did not (7 percent readmission rate for those receiving the service; 10 percent for those who did not). As MRP was found to be successful, PrimeWest Health has attempted to increase the number of members who will accept MRP by coordinating care with our county partners, home care agencies, and hospitals. This project continues to be monitored through our MRP HEDIS measure (now measured through the Transitions of Care HEDIS measure).

- **2018 Recommendation:** HEDIS (Quality of Care) –
  - Women's health: PrimeWest Health should expand its current program to include cervical cancer screenings. PrimeWest Health should also expand its chlamydia screening improvement strategy to include member education.
  - Well-child Visits: PrimeWest Health should consider leveraging its child immunization improvement strategy to increase well-child visit rates [refer to page 146]. For example, when personalized immunization reminder letters are sent to members, this can be used as an opportunity to reminder members about the importance of completing well-child visits. PrimeWest Health should evaluate the adequacy of its pediatric provider network to determine if access issues exist for members.

MCO Response: IPRO recommends including Cervical Cancer Screening (CCS) in our current women's and children's programming. IPRO also recommends providing member education as part of our chlamydia screening improvement activities.

A. PrimeWest Health included the CCS measure in our voucher program from 2017 through 2020. As discussed in our prior year's response, this program included mailing a voucher for a $50 – 100 gift card to members in need of the screening and also involved calling members to remind them of the needed screening. A reminder postcard was also sent later in the year to members who still had not received the screening. Each year's program varied slightly depending on available resources for that year.
B. PrimeWest Health included member education in our chlamydia screening improvement activities over the last several years in the following ways:

i. PrimeWest Health utilized a third party lab vendor to offer at-home test kits for chlamydia screening. PrimeWest Health performed over 500 phone calls to members offering the kits. During these phone calls, the importance of this screening and the ease of completing the test was communicated.
ii. PrimeWest Health sent letters to members in 2019, encouraging chlamydia screenings and educating members about the importance of monitoring their sexual health.
iii. PrimeWest Health placed a Facebook ad in 2020 promoting at-home testing kits, which included member education on the importance of the test.

IPRO recommends leveraging PrimeWest Health's Childhood Immunizations Status (CIS) Interventions to also promote well-child visits. IPRO also recommends examining network adequacy outcomes in the area of pediatrics for improvement opportunities.

PrimeWest Health leveraged our CIS vouchers during 2014 and 2015. This was accomplished by including a $25 voucher for each wellness visit the child received (up to $150) to reach the goal of six visits and to help the child stay on track with immunizations. If all immunizations occurred within the stated time frame, an additional $100 voucher was offered. During 2016, resources for vouchers were reevaluated and lower performing measures were selected for the voucher program as higher priorities. As such, this particular voucher program was discontinued until recently (2020). The importance of immunizations and baby wellness visits has always continued to be a focus for member education through Public Health nurse visits, new mother packets for members, and individualized letters for children with gaps in immunizations. PrimeWest Health will keep the feedback in mind regarding combining outreach efforts in these two areas for future strategies.

Network adequacy is monitored on an annual basis. In 2019, network adequacy monitoring identified an opportunity to improve in the area of pediatrician access as PrimeWest Health did not meet our goal of 95 percent compliance for access within 30 miles of our members' homes. The outcome was 90.0 percent. Because we did not meet this goal, PrimeWest Health made efforts to increase network providers in this specialty. PrimeWest Health was able to add 37 pediatricians to our network in 2020. Network adequacy will continue to be monitored in all areas.

- **2018 Recommendation:** CAHPS (Member Satisfaction) – In addition to the results of the CAHPS survey, PrimeWest Health should identify other means of collecting member feedback and use this information to conduct a thorough root cause analysis. The Health Plan should also evaluate the effectiveness of existing interventions and update and modify them as needed.

  MCO Response: IPRO recommends seeking member feedback through avenues other than the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey and to evaluate prior interventions for modifications. PrimeWest Health analyzes many sources for evaluating member satisfaction. Some of these sources include the following:

  – Member stakeholder groups

- Appeals and Grievances
- Behavioral Health Survey
- Care Coordination Satisfaction Survey
- Access to Care Survey
- Network adequacy analysis
- Suggestion box on our website

Below are a few examples of how PrimeWest Health has used data from the above sources to modify processes or interventions over the last few years.

- PrimeWest Health has encouraged coordination of care between primary care and behavioral health care providers.
- PrimeWest Health has modified our Appeal and Grievance staff training to include an annual training for all staff and added a quiz to assess understanding.
- PrimeWest Health has sought to expand telehealth opportunities for our members, particularly within the area of behavioral health.
- PrimeWest Health has sought to educate our members about community wait time standards to better match expectations to reality. This includes member newsletters articles and education from our call center staff when a member calls asking for assistance with locating certain provider types.
- These interventions are ongoing and continue to be monitored annually based on quality outcomes and survey data.

SOUTH COUNTRY HEALTH ALLIANCE (SOUTH COUNTRY)

- **2018 Recommendation:** 2018 Financial Withhold –
  - Dental Care: South Country should continue with the improvement strategy described in the Health Plan's response to the previous year's recommendation [refer to page 148]. South Country should continue to expand its dental network and utilize the results of the member survey to identify barriers to care.
  - Hospital readmissions: South Country should leverage the hospital admissions reduction strategy to include readmissions [refer to page 155]. South Country should ensure that members with readmissions are targeted for care management.

MCO Response: Dental Care: Dental access remains a challenge for all Minnesota Government Programs. South Country Health Alliance (South Country) has strived to improve dental access through innovative solutions including increased reimbursement rates to providers, increased non-pregnant adults' preventive dental benefits, and community-based reinvestment grants. We have remained an active partner with the Special Needs Basic Care (SNBC) Dental Access Improvement Project from implementation in 2017 through all of 2019. In 2018 and 2019, the Minnesota Department of Human Services (DHS) maintained a quality measure for all members to have at least one preventive dental visit per year. South Country was a participant in the SNBC Dental Access Project workgroup, which is a collaborative effort between the DHS Special Needs Purchasing Division, Managed Care Organizations (MCO) and DHS State Operated Dental Clinics.

The targeted goal of the workgroup was establishing a dental home and reducing inappropriate Emergency Department use, and to see an increase the number of SNBC members having one or more dental visits on an annual basis. Interventions include dental case management, special needs community dentist/staff mentoring programs, and a tele-dentistry demonstration program. The MCO group submitted the final dental report to DHS in May of 2020. The MCOs continue to work together on the collaborative interventions and summarize activities in our annual report. South Country finalized the work on the SNBC Dental Access Project in 2020. The goal was to share strengths, weaknesses and lessons learned with an interdepartmental group with the potential of implementing these strategies across all products. Many useful resources were created as part of this project. South Country will look for innovative ways to expand resource distribution and utilization. In 2018, South Country began contracting with Delta Dental of MN (DDMN) as our dental benefits administrator. DDMN's responsibilities include processing and paying dental claims, contracting with providers, member customer services, provider customer services, utilization management activities, and grievance and appeals. The dental benefits administrator change from DentaQuest to DDMN created challenges in comparing 2017 and earlier year over year statistics. There are now fewer services that require a prior authorization. In addition, DDMN reporting systems differ which result in far fewer Utilization Management (UM) cases reported. As 2019, is our second full year of working with DDMN, we have established a more solid baseline data. As a result of contracting with DDMN our dental network has expanded to 1513 dentists with 2447 total access

points. Also helping dental access, DDMN reimburses non-participating dental providers serving South Country members at the DHS rate.

South Country continues our recruitment efforts in partnership with DDMN, to improved dental access close to our members' homes. South Country puts high emphasis on recruiting and maintaining dental providers within our member counties. Delta Dental's care coordination program assists members with locating a dentist, scheduling appointments, coordinating transportation and interpretation services as needed, and providing both reminder and follow up calls to decrease appointment failure rates. This has proven to be a very valuable resource for South Country members due to the individualized attention given to all aspects of the dental experience. This program also benefits providers which assists with retention of providers serving South Country members.

To illustrate its effectiveness, the program helped over 4,400 South Country members to locate a provider or schedule a dental visit since 2018. Of those, 99.5% successfully kept their appointment which is invaluable to providers and members alike. In 2019, South Country continued a dental incentive to the Be Rewarded! wellness program. AbilityCare, SharedCare, SingleCare, SeniorCare Complete and MSC+ members are eligible to receive a $25 gift card for completing one preventive dental visit during the calendar year. Three hundred SNBC and Senior members redeemed a voucher in 2019. The Be Rewarded! wellness incentive for SNBC and Senior members receiving an annual dental visit was renewed for 2020 and 2021.

Our focus continues to be increasing members going to the dentist at least once a year. South Country implemented a dental focus study in 2019 with a goal to increase the percentage of PMAP and MNCare members, ages 2-20 years of age, receive an annual dental exam. THE HEDIS 2018 Annual Dental Visit measure was used as the baseline rate to determine the expected outcome performance measurement rate. The rate is calculated for each measurement year and the methodology is applied over the course of a three-year measurement (2018-2020) following HEDIS technical specifications. Interventions completed in 2019: 1. Postcards were sent, fourth quarter, to families of PMAP and MNCare members, ages 2-20 years of age, providing general education about the importance of an annual dental exam. 3,578 postcards were mailed to members. 2. A provider newsletter article was published in December 2019 that provided the details regarding the focus study purpose, interventions, and goals. 3. A member newsletter article was published in May 2019 on the importance of seeing your dental provider at least once a year. In 2019, an educational presentation was provided to our Family Health Committee by Cris Gilb, Executive Director of Crush Cavities, a Minnesota Oral Health Project, a project of the University of Minnesota and the Lions of Multiple District 5M, presented a PowerPoint entitled, "Let's Crush Cavities!" The Minnesota Oral Health Project was founded by Dr. Amos Deinard, a pediatrician, who has worked extensively with high-risk children, and has devoted much of the last 15 years to public health dentistry to ensure that high-risk children have access to good dental care. Cris shared that the primary focus of the program is children between birth and their 6th birthday in rural Minnesota with one of their goals

being a 60 to 75% reduction in caries in children ages 0 to 5 in Greater Minnesota by 2022. She shared that caries is the most common chronic disease of childhood and that 50% of caries goes untreated in high-risk children plus 80% of the disease. In April 2020, 250 “Bye Bye Germs” books were mailed to 250 members, age 2 – 8 years of age as an award to those who had completed their annual dental exam.

South Country is committed to working with DHS, dental providers, our communities, and our members to improve dental access for individuals enrolled in all Minnesota Health Care Programs.

Hospital Readmissions

South Country Health Services continues to evaluate and evolve our efforts to identify and intervene with members with readmissions. Our members hospital readmission rates are one area where our internal process was changed. A significant change occurred in how we identify those members. We worked closely with our informatics team to build a report to identify members with hospital eadmission as opposed to our previous process to claims dig (data mine) for member utilization. A few key implementation strategies in the specifications to the report were:

1.) Identify members readmitted to the hospital within 30 days with similar diagnosis. Previous data mining isolated out members hospitalized within 14 days of discharge. This enhancement added value to member readmitting up to a month from discharge expanding the analysis window.
2.) The data is pulled quarterly with a retro look back of 90 days to identify members readmitted. Process Change: South Country’s Health Services process changed to include a registered nurse reviewing each member readmission for a clinical analysis to determine if the readmission within 30 days was related to a similar diagnosis. When proved to meet readmission criteria the registered nurse refers the case to South Country case management team. Complex Case Management team enhancement in process: A detailed claims review is completed by the Complex Case Manager. If the member does meet criteria for Complex Case Management, the Nurses and Social Workers reach out to the member to initiate Case Management. If the member does not meet criteria for the Complex Case Management program, then the member’s referral is passed to the county-based Community Care Connector. In instances where the member expresses interest in face-to-face contact, then the referral is also passed to the Community Care Connector. The Complex Case Management program consists of members agreeing to participate in a program, where a health risk assessment is completed and a care plan developed, to educate, encourage and support the member in achieving goals and a better quality of life. Community Care Connector role enhanced: The Community Care Connector is a position funded by South Country, for an individual to work in and with the counties in the South Country service area. This individual works primarily with the PMAP and MNCare populations around hospitalization follow-up, ER follow-up and utilization referrals including readmissions when appropriate. They are an extension of South Country and provide a face-to-face contact for

the member at the county level. The Community Care Connector assists the members in understanding their benefits, the services they can receive, and support or assists them in receiving needed care. In second quarter 2020 the Health Services team added all products to the reports as well as a process to reach out to those members or refer into the county-based Community Care Connector. Improved discharge planning and post-acute outreach, South Country can improve members' care and prevent costly hospital readmissions. South Country follows Care Coordination policies that describe care transition protocols used to maintain continuity of care for our members. Transition of care services are provided to members when they move from one care setting to another due to a change in health status.

Examples of care transition settings include moving to/from home, home health care, acute care, skilled nursing facility, custodial nursing facility; regional treatment center, outpatient surgery; or rehabilitation facility. Any movement between settings of care is a separate transition, including the member's transition back to their usual care setting. Proactive care coordination is provided to prevent transitions including avoiding unnecessary emergency room visits, hospitalizations, readmissions, and coordinating services for members at high risk of having a transition (e.g., falls, lack of preventive care, or poor chronic disease management). SeniorCare Complete, AbilityCare, MSC+, SingleCare and SharedCare members are assigned a Care Coordinator who is the point of contact for a member before, during, and after a change in care setting (transition).

The Care Coordinator is responsible for completing outreach to the most appropriate individual to assist the member through the transition this could include but not limited to the member and/or the member's authorized representative, nursing home or residential services staff upon notification from South Country. South Country believes that it is critical that the Care Coordinator (and/or someone with knowledge about the member and is located locally) connects and offers support and assistance to the member as soon as possible to ensure continuity of care and begin discussing discharge planning. As part of the care transition process, the Care Coordinator must communicate with the member's Primary Care Provider to ensure they are aware of the member's hospitalization, discuss possible long-term change in health status, and potential needed services or supports upon discharge.

The Care Coordinator is expected to check that the member has a follow-up appointment with their Primary Care Provider as soon as possible. If a follow up appointment is not scheduled the Care Coordinator should assist in scheduling a follow-up appointment for the member if the member will allow this assistance. The Care Coordinator educates the member on the importance of scheduling and keeping appointments and addresses any barriers that may arise.

A part of the Care Coordinator role with follow up after hospitalization or readmission, the Care Coordinator builds trust and a relationship with the member so that members are comfortable sharing health issues and indicators of their condition(s) as part of the health risk assessment process. These indicators and health condition information will be utilized to develop an Individual Care Plan (ICP) that will include self-management activities and will focus on a plan to maintain or improve good health. The ICP also includes strengths, preventive services and needs, mental health information, medication information, and safety plans such as the personal risk management plan. Ultimately, it is the Care Coordinator who has the most contact with the member.

The Care Coordinator must determine whether the member and/or caregiver understand the member's health indicators and appropriate self-management activities, their current medication regime, and whether the member and/or caregiver have knowledge of the warning signs for the member's health diagnosis and know the appropriate steps to take if the member's condition changes. Members are provided with the phone number to contact a South Country Member Services team on the back of their South Country ID card and in their annual member materials. If a member forgets who their Care Coordinator is during the care transition process a member and/or the authorized representative can call South Country and the Member Services team. South Country Member Services team will provide the member/authorized representative the contact information for the member's Care Coordinator.

The Community Engagement Department staff train and assist Care Coordinators who work directly with members when the member moves from one care setting to another due to a change in health status. The Community Engagement team completes an audit of the Transitions of Care Logs/care transition process to ensure that members experience a smooth and seamless transition of care across healthcare settings, providers and health and social services.

South Country staff complete at a quarterly Transitions of Care Logs/care transition process audit. A sample of Transitions of Care logs from the previous quarter will be audited. for the transition are audited for example: admission to the hospital, discharge to a nursing home and then discharge from the nursing home back to the community. The sampling methodology will follow the NCQA 8/30 process. Eight (8) transitions from the previous quarter will be selected and all transitions related to the eight (8) selected transitions will be reviewed. If any areas in the first selected transitions another twenty-two (22) transitions will be selected. All transitions related to the next twenty-two (22) transitions will be reviewed. South Country reviews the entire transition that the member experiences to ensure that it is seamless. This audit allows South Country to determine the effectiveness of the transition process in place and adjust or provide training as needed. South Country transitioned our utilization management program internally in 2019, along with changing

our medical claims third-party administrator from MMSI to PrimeWest Health. On a quarterly basis, the Director of Health Services, and the Chief Medical Officer (CMO) or Medical Director provide data and program results to the UM committee – a sub-committee of the Quality Assurance Committee (QAC). Another subcommittee, the Medical Policy Review Committee, was also established and is made up of clinicians who review and institute recommendations for criteria to be used for authorization determinations, along with reviewing South Country Medical Coverage policies on an annual basis. This committee also meets quarterly and reports to the UM committee.

- **2018 Recommendation:** HEDIS (Quality of Care) – As women's health and child and adolescent care continue to be opportunities for improvement, South Country should conduct evaluate the effectiveness of its current quality improvement strategy and modify it as needed.

  MCO Response: South Country contracts with independent companies to assure accuracy of HEDIS measure rates and to facilitate the processes associated with collecting data, assembling reports, and validating results. The full complement of HEDIS measures consists of many topics across different domains of care, such as preventive care services, chronic conditions, behavioral health, and access / availability of care. HEDIS measures are calculated from medical and pharmacy claims data (administrative measures) or from claims data supplemented by medical record reviews (hybrid measures).

  HEDIS 2019 rates are based on 2018 calendar year enrollment, claims, and medical record data. South Country's Health Informatics Analyst and Quality Program Coordinator reviewed results for clinical and statistical validity. In addition, evaluation of measures to assess etiology and causal factors that may have impacted the rates and to identify areas or measures that require improvement initiatives. Results were shared with Leadership and the Quality Assurance Committee for additional discussion regarding opportunities for further improvement. As women's health and child and adolescent care continue to be opportunities for improvement South Country continues to provide specific interventions focused on improving the overall health for women and children through the following promotions and interventions:

  - South Country's Be Buckled Car Seat Program provides one car seat per child age 7 and younger, per lifetime, along with training about how to safely use the car seat. In 2018, South Country in partnership with our County Public Health Agencies distributed 451 car seats. In 2019, South Country in partnership with our County Public Health Agencies distributed 466 car seats.
  - The "Embracing Life Special Guide and Calendar for Moms" was changed from hard cover to paperback making it easier for our members. This prenatal guide and calendar is mailed out to new and expecting mothers. It has helpful information about prenatal care and care for newborns during their first year of life. We also provide more robust information and resources online as an extension of the information included in this book. A barcode was

added to the book that members can scan with their smartphone to easily access the website.

- Childbirth & Pregnancy Education Classes are paid for by South Country. Expecting mothers can take pregnancy and childbirth classes in a clinic, hospital, public health agency, or through Community Education at no charge.
- South Country covers the cost of a breast pump for new mothers.
- Prenatal Care and Postpartum Visit vouchers were combined in 2019 into one $50 gift card Pregnancy Care Voucher for completing any five of their prenatal visits in addition to one postpartum visit within 21 to 56 days after delivery.
- Infant Well-Care Visit Voucher reward was changed in 2019 to a $50 gift card for having at least six wellcare visits prior to the age of 15 months. In 2018, South Country mailed 42 gift cards. In 2019, South Country mailed 50 gift cards.
- Young Adult Well-Care Visit reward was changed to a $10 gift card with a $10 gift card bonus for completing a Chlamydia Screening. South Country has a Family Health Committee which serves as a resource for the development, implementation, and review of South Country's family health programs and services including health promotion programs and member benefits. Representing South Country's eight (8) member counties, committee members provide input on how South Country's health promotion programs and other family health services function at the county level. The committee meets at least three times a year to discuss:
    1. Advising South Country on member health promotion program design, implementation, and maintenance.
    2. Providing feedback on the general operations of South Country's health promotion and other family health related programs at the county-level.
    3. Bringing forth county questions, concerns, and issues for discussion as they relate to South Country's family health related programs and services. South Country developed a pregnancy project, where the pregnancy information is obtained from claims data and then letters are sent to newly pregnant members. Enclosed with the letter are South Country's pregnancy brochure, EX program smoking cessation brochure, Pregnancy Care voucher and "Embracing Life Special Guide and Calendar for Moms." Complex Case Managers call members with High-Risk Pregnancies to offer case management, answer questions, and make referrals for other services, such as WIC, mental health, etc. Members that qualify for Complex Case Management due to a high-risk pregnancy are offered a specialized assessment and care plan pertaining to high-risk pregnancy.

- **2018 Recommendation:** CAHPS (Member Satisfaction) – South Country should conduct root cause analysis on all poorly performing CAHPS® measures and implement initiatives to address identified barriers.

MCO Response: The results of the CAHPS surveys are integrated into the overall Quality Improvement (QI) Plan as they provide benchmarks for assessing South Country's performance with member satisfaction from year to year. In addition, downward trends in areas such as experience with customer service, getting needed care, and timeliness of care can be easily identified and readily addressed through a collaborative effort between South Country staff, county staff (particularly care coordinators), and the provider network. South Country's Quality, Health Services, Community Engagement and Provider Network departments, as well as Leadership team, annually evaluate results from the CAHPS surveys and identify priority areas for improvement. One notable change for the 2018 to 2019 CAHPS data is the change in vendor utilized by DHS. South Country had two (2) lower performing CAHPS measures in 2018 for our PMAP population. One measure that was lower than the state average for Rating of Personal Doctor in 2018, has shown an improvement from 68.6% in 2018, to 73.8% in 2019, and up to 76% in 2020. South Country is 4.4% higher in the Rating of Personal Doctor than the state average in 2020. We continue to work closely with our members and providers to ensure members are satisfied with providers in our South Country network. Our second measure that was lower for PMAP was Rating of Specialist Seen Most Often. South Country did not see much change in this rate between 2018 at 65.6% to 65.5% in 2019. In 2020 it is worth noting that we did see a large decline to 58.7%. South Country continues to evaluate the root cause of this feedback from members. Potentially, the members who are responding may minimally see or utilize specialist providers, impacting to lower numbers compared to the state average. PMAP survey results showed improvements from 2018 to 2019 in: Rating of All Health Care, Rating of Personal Doctor, Getting Needed Care, Getting Care Quickly, Coordination of Care, and Health Promotion and Education. South Country had seven (7) measures that are lower than the state average for MinnesotaCare. These measures are Rating of Getting Needed Care, How Well Doctors Communicate, Customer Service, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often and Rating of Health Plan. Due to the process and combining of health plans for CAHPS surveys, a root cause analysis is difficult to complete as these measures South Country are combined with Hennepin Health, Itasca Medical Care and Prime West Health as we all have a smaller number of members in MinnesotaCare. Our MinnesotaCare population is about 6% of our overall membership. Our largest product rates Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often are above the state average. MinnesotaCare survey results showed improvements from 2018 to 2019 in: Rating of Health Plan and Rating of Personal Doctor. For MSC+ we had one measure that was slightly below the state average in 2018 and that was Rating of All Health Care. This measure was slightly below in 2018 it improved in 2019 then declined a bit in 2020. Our 2020 rating of 57.7% is higher than the state average of 56.7%. MSC+ survey results showed improvements from 2018 to 2019 in: Getting Needed Care, Shared Decision Making and Coordination of Care.South Country uses the results of multiple surveys to directly assess member satisfaction and experience with us as their health plan, their health care providers, and the health care services they receive. This process provides valuable insight into how we are meeting the needs of our members and where there are opportunities for improvement. Member satisfaction is continually assessed through multiple processes including Member

Satisfaction and Effectiveness of Care Coordination surveys, Member Satisfaction of home care services surveys, and quarterly reviews of both Grievance & Appeals. These surveys allow us to identify potential gaps in service delivery and member satisfaction to assess underlying factors, identify barriers and determine strategies for ensuring continued success in meeting the needs and expectations of our members. Due to South Country being combined with the other small health plans we are considering adding some of the same questions asked on the CAHPS survey to our existing South Country surveys for the purpose of clean data collections and reflection of South Country specific responses. South Country's Leadership Team and Quality Assurance Committee Team review survey results and strategies are identified to improve member satisfaction. Strategies may include continued improvement and implementation of focused marketing and education to new and current members.

UCARE

- **2018 Recommendation:** 2018 Financial Withhold – UCare should continue with the robust improvement strategy described in the Health Plan's response to the previous year recommendation to address dental care and hospital readmissions. UCare should routinely evaluate the effectiveness of the improvement strategy and modify it as needed.

  MCO Response: Dental Care: UCare's prevention workgroup is dedicated to improving access to dental providers, and in 2018 and beyond, UCare conducted a number of different initiatives to try to improve this rate. Intervention strategies that were implemented to improve efforts for dental access included:

  Member Initiatives

  UCare initiated a member outreach program in 2017 and have continued outreach. UCare's Member Engagement Specialist reached out to two different groups; members who had a gap in care for dental access and members who utilized the emergency department (ED) for non-traumatic dental needs. Telephonic outreach was conducted to provide education on the importance of the annual dental exam, assist members in scheduling an appointment and to help the member find a dental home. If connection with the member or caregiver was not made, a letter was sent to inform them of their dental benefits and where to call if they need assistance with scheduling a dental appointment. In addition, the Member Engagement Specialist worked with UCare's Dental Benefit Manager Delta Dental of Minnesota (DDMN) regarding assistance with scheduling a member's dental exam or if there were concerns with finding the member a dental home.

  Along with personalized direct member outreach, UCare sent non-compliant members various communications, such as postcards and IVR calls. UCare offers supplemental benefits including:

  - $25 preventive dental exam reward
  - Dental kits:
  - Child Dental Kit: Child-sized toothbrush, floss pick, toothpaste, timer, dental care tracker and Curious George book
  - Adult Dental Kit: Rechargeable toothbrush with charger, two extra brush heads, toothpaste and dental floss

  Provider Initiatives

  - UCare also led collaboration efforts with Direct Care & Treatment—Dental Clinics (DCT-DC). This intervention encouraged additional education regarding the care of Medicaid patients.
  - Materials and outcomes based on feedback provided by DCT-DC collaboration include:
  - Dental Provider Toolkit
  - Developed a dental care MCO 101 grid. The grid was designed for dental clinics, care managers and counties as an easy-to-use tool that outlines important dental-related

information for each health plan that offers Medicaid products. Topics included in the grid are additional dental benefits, referral resources, contact information–member and provider–incentives, etc.

- Developed a patient decision tree to assist caregivers in identifying appropriate individuals to refer to DCT-DC for dental care and treatment.

Many Medicaid members present with additional medical and dental needs that may warrant more frequent dental care than other patients. UCare acknowledges that the dental provider is in the best position to identify the patient-specific preventive care plan and that the existing prior authorization requirement was burdensome. UCare decided to remove the prior authorization requirement for additional (more than two) dental cleanings for our members. This will benefit the dental clinics in reducing workload and administrative staff time for these prior authorizations. Saving administrative time with this new process will increase time for the clinics to devote to access and care for special needs patients.

Further, UCare continues to explore provider partnerships in the community to improve access and utilization. UCare is working with dental providers to reach out to UCare members, using value-based contracting with primary care providers to foster engagement and education with members. Additionally, UCare has a partnership with DDMN to provide member engagement outreach and additional dental care coordinator support.

Despite UCare's efforts, our dental utilization rates continue to remain stagnant. UCare is aware that several barriers prevent Medicaid members from seeking dental care that include:

Lack of education about the importance of oral health care and frequency of seeing a dental provider has resulted in poor oral health.

- Lack of awareness about dental benefits and coverage. Medicaid populations were often unsure of their dental benefits while on Medicaid or had a false understanding of what their benefits actually covered.
- Insufficient numbers of dentists who accept Medicaid. Many dentists are reluctant to accept Medicaid patients because Medicaid typically pays a little as half of what private insurance pays for the same procedure. Also, dentists believe that Medicaid doesn't cover enough dental services.
- UCare recognizes that dental health is an important part of people's overall health and well-being and all members deserve good dental health. We know that most prevalent oral conditions are dental caries and periodontal disease, which are largely preventable. UCare continues to design interventions and initiatives to increase dental utilization amongst our members. Intervention are designed to
- Increase awareness of the importance of oral health care
- Communicate covered services and benefits regarding oral health care
- Reduce disparities in access to effective preventive and dental treatment services

- Initiatives that will continue to support our members in utilizing dental care include:
- Member engagement – telephonic outreach, interactive voice response calls, incentive mailings
- Educational materials – member score card, postcard reminders
- Provider engagement – partnerships, value-based contracting

Hospital Admissions and Readmissions

Mental Health & Substance Use Disorder (SUD) Admissions and Readmissions:

The Medical and Mental Health & Substance Use Disorder (SUD) Utilization Management (UM) Workgroups are comprised of multidisciplinary teams that review quarterly data, collected by the Health Care Economics team, of over/under measures related to Emergency Department use and Hospital Inpatient admissions and reviewed at quarterly UM Work Group Meetings.

Effective 2019, the Mental Health and Substance Use Disorder Workgroup added a review of the Follow Up After Hospitalization for Mental Illness (FUH) HEDIS measure for both seven and thirty days to track the rate of members that attend a follow up visit with a mental health practitioner within seven and thirty days of a mental health related inpatient stay.

In 2019, the workgroup determined that there is opportunity for improvement within the rate and took the following action. The mental health and SUD utilization management and case management teams connect with Families and Children Medical Assistance (MA) and MinnesotaCare (MnCare) members who are experiencing a mental health inpatient stay to assist them with making a follow up appointment with a mental health practitioner. UCare staff members work with both the member and their team at the inpatient facility to set the appointment and to assist with removing any barriers to attending the follow up appointment (e.g. assist with scheduling transportation). In addition, the UCare staff member will connect with the member post-discharge to ensure the member attended the appointment and to help facilitate a smooth transition back into the community. The goal of our outreach and collaboration is to educate members on the importance of follow up and to help reduce the number of preventable readmissions.

In addition to the FUH work noted above, care coordinators and case managers are also involved in assisting members with transitions of care. UCare has a daily admission report that identifies any member that is connected to a case manager that has an inpatient admission of any type. Similar to the follow up after hospitalization process, the case manager will reach out to the facility to identify if the member remains admitted or if they have discharge. The case manager will work with the discharge provider to identify any barriers to discharge and any post-discharge needs. If the member is discharged the case manager will reach out directly to the member and will ensure that the member has a follow up after hospitalization discharge appointment with the appropriate provider, the appropriate medication, understanding of discharge instructions, and any need for community resources or referrals.

Minnesota Restricted Recipient Program (MRRP): UCare maintained a high rate of enrollment of members in this program throughout calendar year 2019, with an average monthly enrollment of over 560. In 2019, we analyzed health care utilization of members who were enrolled in the MRRP within the reporting period of calendar year 2018. Overall, health care utilization was lower for members after the date of restriction. Emergency room visits decreased by 46%, inpatient hospitalization trended down by 36%, office visits dropped by 32%, and prescriptions were 21% fewer.

Monitoring:

The HEDIS rates are presented to both the Medical and Mental Health and Substance Use Disorder UM workgroups to help create broader awareness and provide an integrated approach to data review and interventions.

The Mental Health and Substance Use Disorder Case Management Team audits transitions of care internally on a monthly basis to:

- Ensure that our case managers are completing the transition of care process within two business days of the notification of the admission.
- Ensure that our case managers are addressing the four pillars of care transitions with our members
    - Medication self-management
    - Follow up appointment scheduled
    - Communication with the primary care provider
    - Red flags/indicators that their condition is worsening.

The MRRP and case management interventions related to decreasing unnecessary hospitalizations and readmissions is reviewed annually as a part of the internal program evaluation.

If additional opportunities are identified while evaluating effectiveness, additional interventions are discussed and implemented as needed.

Member Barriers to Reducing MH/SUD Admissions/Readmissions:

- Unstable housing
- Contact information for members is sometimes inaccurate creating difficulties in reaching a member post-discharge from the hospital
- Engagement in the follow up process. Members may not always understand or have the ability to prioritize follow up appointments

Provider Barriers to Reducing MH/SUD Admissions/Readmissions:

Having enough psychiatric (medication management) appointments available to a new patient discharging from an inpatient setting. This can be especially difficult in rural region, although telehealth is improving this considerably. UCare is working to mitigate this barrier by having pre-purchased medication management appointments available to members.

Medical Admissions and Readmissions:

The Medical Utilization Management Workgroup is comprised of a multidisciplinary team that reviews quarterly data of over/under measures collected by the Health Care Economics team related to Hospital Inpatient admissions. In 2020, the workgroup performed a special study to review long-term acute care hospital (LTACH) admissions to determine the average length of stay for UCare members in comparison to the national average. It was identified that UCare's LTACH average length of stay (LOS) is around twenty-eight days and the national average length of stay is 26.3 days in an LTACH. This data identified an opportunity for improvement with managing a length of stay and assisting LTACH facilities with transitioning members to lower level of care once member is deemed to be stable.

The Clinical Services Medical Team, along with representatives from Case Management (CM), Medical Directors, Pharmacy, and Mental Health & Substance Use Disorder Services (MSS) teams established a weekly Multidisciplinary Case Rounds meetings in quarter four of 2020 to discuss complex cases (i.e.: neonatal intensive care unit (NICU) admissions, transplants, complex needs, etc.) to ensure the member's needs are met across all levels of care and during transitions of care. UCare staff recognize an effective discharge plan is dependent upon strong communication and collaboration with the hospital team, members, and/or member's power of attorney (POA) to assist with identifying discharge barriers with the goal to provide support while removing such barriers to assist with care transitions. The Clinical UM team requires prior authorization (non-COVID) for admission to an LTACH to ensure the member meets criteria at this level of care which includes evidenced-based criteria for ventilator weaning, wound care management, therapies (such as physical, respiratory and occupational), and other nursing care needs. If the member meets criteria, the UM staff reviews clinical documentation throughout the stay completing reviews approximately every fourteen days (more frequently if member is progressing more rapidly than expected) until the member discharge. The UM staff review clinical documentation and begin conversations with LTACH staff regarding discharge process upon member's admission to prepare for and identify discharge needs post-discharge. As the member approaches stabilization, the UM staff submits a referral to Case Managers (CM) when identified opportunities exist; and, UM staff work closely with CM staff for early intervention to provide a smooth transition to a lower level of care with the goal to reduce preventable readmissions. When necessary, UM staff will arrange for a physician to physician discussion to gain clarity on member's progress if documentation is not clear or ambiguous.

In addition, UCare has a shared clinical documentation system which provides a comprehensive overview of the member's status to which both UM and CM teams have access as they work with UCare's members.

The above process will be ongoing in 2021. The UM Work Group will continue to assess the impact of UM-CM collaboration to improve the quality of care for UCare members.

Member Barriers for Reducing Medical Admissions/Readmissions:

- Member is unstable for discharge or transition to lower level of care
- Certain conditions prohibiting member's ability to engage in conversation
- Certain behaviors requiring restraints or 1:1 monitoring prohibiting member's ability to discharge
- Contact information for members/POA/family is sometimes inaccurate and can be difficult to reach a member who is hospitalized
- Homelessness or familial discord can impact decision making to lower level of care
- Member is out of state and not stable enough to transport back to Minnesota
- Member's insurance lapsed during acute care hospitalization and LTACH admission
- Language/cultural barriers

Provider Barriers for Reducing Medical Admissions/Readmissions:

- Services are provided to the most acutely ill members
- Lack of adequate resources to find facilities with openings for lower level of care needs
- Awaiting placement to an outside facility
- 2020 global pandemic has impacted all healthcare providers to varying degrees with limited capacity to accept new members with complex needs and has resulted in closure of others
- Some hospitalized members are followed by multiple specialists who may not agree on care needs
- Hospital-acquired infections or medical complications while hospitalized

Given the work being done with UCare's LTACH member population; and, to meaningfully reduce readmissions, UCare's UM-CM teams recognized it to be important to integrate across workflows. Beginning 1/1/2021, UCare is implementing a process for clinical review updates for medical/surgical acute care inpatient hospital admissions greater than seven days, and, maternity acute care inpatient admissions greater than five days with the goal to distinguish members at risk of being readmitted while engaging CM staff timely to reduce preventable readmissions. UM staff will align acute inpatient hospital review much like the LTACH explained in the former response: The Clinical UM team will work closely with the acute care hospital requiring clinical documentation throughout the stay completing reviews approximately every one through seven days (more frequently if member is progressing more rapidly than expected) until member discharge. The UM staff review clinical documentation and begin conversations with acute care staff regarding discharge process upon member's admission to prepare for and identify discharge needs and post-

discharge needs. As the member approaches stabilization, the UM staff submits a referral to CM when identified opportunities exist; and, UM staff work closely with CM staff for early intervention to provide a smooth transition to a lower level of care with the goal to reduce preventable readmissions. When necessary, UM staff will arrange for a physician to physician discussion to gain clarity on member's progress if documentation is not clear or ambiguous.

As needed, the nurse reviewer will speak to such case at the weekly Multidisciplinary Case Rounds meetings.

In addition, UCare has a shared clinical documentation system which provides a comprehensive overview of the member's status to which both UM and CM teams have access as they work with UCare's members.

The above process will be ongoing in 2021. The UM Work Group will continue to assess the impact of UM-CM collaboration to improve the quality of care for UCare members.

Special Health Care Needs Program:

The intent of the Special Health Care Needs Program is to identify members with special health care needs, offer and provide case management services as appropriate, assist with access to care and monitor their treatment plans. All Minnesota Health Care Programs (MHCP) members are eligible for case management through this program. UCare identifies adults and children with special health care needs by regularly analyzing claims data for specific diagnoses and utilization patterns as well as through screenings, requests for services and other mechanisms or "triggers." UCare has established monthly rolling thirteen months and year to date monitoring reports. Analysis in 2019 demonstrated that in the adult population, hospital readmission within fourteen days for a similar diagnosis decreased by 25% year over year based on members/1000. Alcohol dependence with withdrawal and type one diabetes mellitus with ketoacidosis without coma were the top two diagnosis' for readmissions. In the pediatric population, hospital readmission within fourteen days for a similar diagnosis decreased by 35% based on members/1000. Encounter for antineoplastic chemotherapy and acute respiratory failure with hypoxia were the top two diagnosis' for readmissions in 2019.

UCare implemented a complex case management in accordance with NCQA standards to include Families and Children MA and MnCare members. Members identified through the Special Health Care Needs Program may be enrolled in this program due to their more complex health care needs. They will then receive a more focused and frequent case management engagement approach. In addition, UCare performs an annual population assessment of each product which assists in determining prevalent chronic conditions within the population. This allows the teams to identify areas for intervention, such as heart failure, which was found to have increased in the Special Health Care Needs population. As a result of this, the team worked with the UCare Disease Management to coordinate referrals to the UCare heart failure program.

Transitions of Care (TOC):

Defined as the movement of a member from one care location to another, transitions have the potential, if not done effectively to lead to higher hospital admission rates. UCare understands this and has had a transition of care process in place for many years for its care coordinators. UCare also publishes its TOC expectations in its provider manual.

UCare care coordinators assist members with all care transitions, and UCare continues to work to improve TOC documents and processes that assist care coordinators in this work. To prevent readmissions, case managers provide education for members or responsible parties about transitions and how to prevent future transitions, to prevent re-admissions.

UCare conducts annual TOC reviews to monitor compliance with transitions of care processes and identify the need for potential process modifications. UCare's goal is that care coordinators strive to be 100% compliant with each element. UCare has maintained this review for the past several years. 2019 analysis of 2018 data findings showed varying degrees of compliance with the transition of care requirements. Measures surrounding education on the transition process showed an increase from 2018 to 2019, as did communication to the member or their representative about changes in the member's condition. Sharing of the plan of care and notification of the primary care physician of the transition within one business day occurred 90% of the time or greater. UCare shares this information with care coordination delegates at meetings and through newsletters to promote learning and process improvement.

- **2018 Recommendation:** HEDIS (Quality of Care) – UCare should continue with its current strategy to address areas of care that continue to perform poorly. UCare should expand this strategy to include diabetes and childhood immunizations.

  MCO Response: Diabetes: UCare has implemented intervention strategies to improve efforts for our members with diabetes. Some of these strategies are:

  - Diabetic call campaigns (including IVR calls and member outbound calls) were conducted to assist members with scheduling an appointment.
  - Newsletter articles were written to educate members and providers about diabetes management for A1c, nephropathy testing, and diabetic eye exam.
  - Monthly, members who had a gap were identified as having a gap in care received an incentive voucher providing education and prompting to schedule diabetic screenings.
  - UCare vendor Cardiocom nurses conducted Diabetes (A1C, retinal eye exam & nephropathy) screening reminders to members participating in the Cardiocom program.
  - The Disease Management Health Coaches continue to discuss gaps in care for those members participating in the diabetes program related to their diabetic needs.

Diabetes Health Coaching:

The diabetes health coaching program supports diabetic screening measures and annual Primary Care Provider (PCP) visits through the program. This is demonstrated through various aspects of the program and encouragement of member adherence.

- Implemented pre and post program questions related to diabetic screenings as part of health coaching program
- Members create self-management behavior change goals to adhere to screening recommendations
- Health coaches provide education and coaching related the importance of adherence with diabetic screenings
- Encourage members to utilize the "Know Your Numbers" chart in member educational materials to track test results and goals
- Members enrolled in the diabetes health coaching program are anticipated to show improvement or continued adherence on diabetic screenings because of program participation. Annually, diabetic screening data is compared to program participants to determine adherence and/or improvement in diabetic screenings.

Childhood Immunizations

UCare has implemented intervention strategies to improve efforts for well care access to PCPs which included improving immunization rates. Some of these strategies are:

- Development of a three-pronged approach to target members who have not seen their primary care provider. Strategies included an IVR call, followed by telephonic outreach, followed by an incentive mailing (additional details listed below)
- Interactive voice recording calls to prompt members to get their well child visit and flu vaccine
- A Member Engagement Specialist made calls to members to provide education over the phone (specifically on the importance of a well-child visit, immunizations), assist in scheduling well child visits and, as needed, with scheduling transportation and an interpreter
- A $25 incentive for completing an annual well care visit
- Collaboration with Parents in Community Action (PICA) to provide education on well child, adolescent well care and postpartum care visits
- Customer Services hold-time messages and articles for members and providers on the importance of scheduling C&TC visits and receiving immunizations
- Collaboration with providers by sending action lists to address gaps in care
- Member score card to prompt members on gaps in care
- Documentation and education to providers on the HEDIS hybrid measures (e.g. well child, refusals, immunizations, etc.)

- Reviewed providers rooming and well child template to help improve documentations
- Collaboration with community groups for various C&TC initiatives and educational opportunities including immunization education

UCare strives to expand proven intervention strategies to reach additional members and explore intervention strategies that include working more collaboratively with providers and outreach to identify culturally specific interventions to work more effectively with our membership. Other key areas of focus will be to realign the workgroup structure. Further, Quality Management and Health Care Economics will continue to work collaboratively together to help prioritize measures and monitor trending data.

- **2018 Recommendation:** CAHPS (Member Satisfaction) – In addition to the results of the CAHPS survey, UCare should identify other means of collecting member feedback and use this information to conduct a thorough root cause analysis.

  MCO Response: UCare has a member experience manager and a cross-departmental member experience workgroup that reviews data annually and develops improvement activities and interventions based on enrollee's feedback provided in the CAHPS survey. UCare combines the CAHPS data with other data sources collected throughout the organization to get a comprehensive view of member satisfaction with UCare plans. Data sources include appeals and grievances, member focus groups, internal member surveys, customer service call monitoring, speech miner, post-call surveys, and other member feedback received directly from customer service and sales representatives. Based on the annual analysis of each of these data sources, UCare identifies select measures to formulate interventions to improve member satisfaction.

  Each year we measure member satisfaction scientifically by hiring third-party survey firms to conduct broad population surveys. The surveys are statewide for our all of our Minnesota Health Care Program members: UCare Families and Children Medical Assistance, MinnesotaCare, SNBC, SNBC+ Medicare, MSHO and MSC+ plans. The surveys are conducted in our membership's top languages and include over-sampling to ensure adequate representation of non-English speaking members. The survey is brief and designed to measure satisfaction across a broad randomly sampled population. Respondents are asked about their satisfaction with benefits and other services such as transportation, customer service and fitness programs. We analyze our data by race, ethnicity, language and geography to look for trends in member experience and satisfaction in different communities.

  Starting later this year, UCare will be conducting an additional satisfaction survey via email. All members with valid email addresses will receive the survey on their 6-month anniversary with UCare and every year thereafter. With this survey, we will be able to capture member satisfaction in real time.. The questions will focus on general member satisfaction with the plan, ease of accessing services and effectiveness of our member communications.

UCare conducted the following quality improvement activities based on various CAHPS measures and continue to refine these strategies annually:

- UCare conducted an off-cycle survey to collect more targeted data from UCare's MSHO, Connect + Medicare, and MSC+ members starting in 2018. This survey will be an annual ongoing intervention, conducted each summer. The survey allows UCare to learn about member experience navigating the health care system and in turn helped identify opportunities for improvement.
- This survey is comprised of various CAHPS and Health Outcomes Survey (HOS) questions. The non-blinded survey was sent to all eligible MSHO and Connect + Medicare members and a sample of 2800 UCare Medicare members and 800 MSC+ members. UCare added a free text box to allow members to provide qualitative responses to CAHPS questions to assist UCare in understanding strengths, as well as opportunities for improvement specific to member needs.
- UCare analyzed the data based on various demographics trends including metro, rural, New Americans, and individuals recognized as high-needs members. Attributed provider group, member primary diagnosis, age, and other identifying factors were also analyzed. UCare formulated workgroups to identify resolutions and to improve member experience, and the workgroups included: Customer Services, Medical and Dental Provider Network, Clinical Services, and Pharmacy.
- UCare's Provider Relations and Contracting Team worked directly with providers to inform them of identified strengths and opportunities for improvement based on member feedback.
- UCare's Pharmacy Team performed a six month look back of members to understand experience with the drug plan, as well as review any appeals or grievances members had with the drug plan to assist with resolution.
- UCare was able to identify members that had a negative experience and provided direct outreach to the member based on the concern. UCare identified members who listed dental access as a concern and a UCare Member Engagement Specialist completed outreach to ensure the access issue was resolved or assisted the member in finding a dental provider.
- Quality Improvement also is working more collaboratively with Customer Service representatives, Care Coordinators, and Sales Team representatives and requested feedback regarding low scoring CAHPS questions from the members' perspective. Quality Improvement also asked about what training opportunities these individuals would benefit from to improve member experience. Based on this feedback, the goal was to provide more effective ongoing trainings to the groups who have more direct contact with members regularly.
- Customer Services uses post-call surveys which are offered to customers on all of our product lines. Prior to a call being delivered to an agent, random calls will be selected by the system, using a threshold specific to each queue which can be set by Customer Service. The

customer is asked five questions and can leave us a message at the end about their experience. Customer survey results are pulled daily and analyzed by the Quality Advocate. In situations where a deficiency includes regulatory requirements, or where service recovery is needed, or if the customer is requesting a call back, the Quality Advocate notifies the appropriate supervisor for immediate coaching and service recovery as applicable. A report is prepared monthly summarizing the department results; root cause and trends are identified, and action plans are developed to address those deficiencies.

Member Advisory Committee - Families and Children Contract Members:

UCare has Member Advisory Committees for each of our MHCP products. These committees or feedback sessions meet three to four times per year and presents a regular opportunity to gather more qualitative member experience feedback – to get a "real world" perspective on survey conclusions. To account for member preferences, staff reach out individually to members who prefer to provide feedback one-on-one. We also use these groups to gather member experience feedback on operational materials, service models and benefit designs.

UCare will continue to work on improving member satisfaction and CAHPS scores, as they are an integral part of the organizations efforts to measure and improve healthcare quality for our members.

CHAPTER 7: MCO FEEDBACK ON 2019 ATR

The DHS/MCO Contract, Section 7.5.3, states that each MCO shall be provided with the opportunity to review and comment on the final draft of the ATR prior to publication. This chapter presents MCO feedback on the final draft of the 2019 ATR. MCO comment resulting in modification to the ATR is noted as "addressed."

BLUE PLUS

- Annual Quality Assurance Work Plan for 2019: change Blue Cross to Blue Plus. ***Addressed.***
- Evaluation of the 2019 Quality Assessment and Performance Improvement Program: change Blue Cross to Blue Plus and accept deleted sentence. ***Addressed.***
- Quality Improvement Program Website: change BCBS to Blue Plus. ***Addressed.***
- Blue Plus Response to Previous Year's Recommendation: change Blue Cross to Blue Plus. ***Addressed.***

HEALTHPARTNERS

- Corporate Profile: change 2018 to 2019. ***Addressed.***
- Throughout report, change HealthPartners' to HealthPartners. ***Addressed.***
- Table 13 description: update to reflect HealthPartners. ***Addressed.***
- Annual Quality Assurance Work Plan for 2019: change cost to costs and add a period to the last sentence in the paragraph. ***Addressed.***
- HEDIS Tables: update rates to reflect what HealthPartners reported to NCQA. ***See the IPRO comment below.***

  IPRO Comment: For the 2020 HEDIS reporting period (measurement year 2019), HealthPartners received DHS approval to report 2019 HEDIS hybrid rates (measurement year 2018) in place of 2020 HEDIS hybrid rates. To be able to appropriately trend MCO performance year-over-year, DHS calculated administrative rates are also used for the historical reporting periods included in the HEDIS tables. Additionally, statewide averages also derive from DHS's administrative data. As DHS relies on administrative data sources to calculate HEDIS rates, DHS successfully captured and reported rates for measurement year 2019. As such for consistency in the HEDIS Tables, IPRO and DHS made a joint decision to utilize the most current data available, which was reported by DHS. IPRO's use of the most current data available results in recommendations that are relevant and timely.

HENNEPIN HEALTH

- Minnesota Health Care Programs, page 1 – first sentence. Hennepin Health is not listed as one of the eight MCOs. There are only seven MCOs listed. ***Addressed.***
- The MCO Clinical Practice Guidelines, page 62-63. The Clinical Practice Guidelines listed in the ATR report were adopted by Hennepin Health for 2019. Please add the following guidelines to the sources. Keep the list as is EXCEPT Add the following:

- Under AAFP – Add Preventive Services Adult – Summary of Recommendations for Clinical Preventive Services
- Under USPTSTF, Section 3 – add Preventive Services – Children/Adolescents
- Under ISCI – Add ADHD Endorsement Summary ***Addressed.***

- Hennepin Health HEDIS Measure Matrix, page 67 – Box C – missing bullet point by Well Child visits. ***Addressed.***
- Hennepin Health Findings and Recommendations page 70. Under "Strengths", bullet four – states HealthPartners. It should be Hennepin Health. ***Addressed.***
- Hennepin Health Opportunities, page 70. Under "Financial Withhold", F&C/MNCare – Provider Network Service Mix: Restorative vs. Preventive. DHS assigned no points to this withhold; therefore, there were no points to receive. DHS did not provide a benchmark or performance rates on the DHS withhold reports in 2019. Therefore, this is not opportunity. Please remove. ***Addressed.***
- Hennepin Health Recommendations, page 71. There is not a recommendation about Quality of Care (HEDIS), although it is listed under an opportunity. ***Addressed.***

ITASCA MEDICAL CARE

- Remove the SNBC label and replace it with MSHO MSC+ in the table on page 74. ***Addressed.***

MEDICA

No suggested edits.

PRIMEWEST HEALTH

- Page 109 is missing a header in the CAHPS table in the 4th column. ***Addressed.***

SOUTH COUNTRY HEALTH ALLIANCE

- Change all SCHA references to South Country. ***Addressed.***
- Performance Improvement Projects: accept edits. ***Addressed.***

UCARE

- UCare Response to Previous Year's Recommendation: accept revisions to plan response. ***Addressed.***
- UCare's rate for CIS Combo 3-Childhood Immunization Status for F&C-MA is incorrectly reported in the 2019 ATR document. The DHS reported administrative rate is significantly lower than the hybrid and administrative rates calculated by UCare. ***See the IPRO comment below.***

  IPRO Comment: IPRO and DHS will follow-up to investigate and better understand the observed differences in the administrative rates reported by UCare. To provide year-to-year trends for plans who sought exemptions from hybrid reporting requirements for the 2020 HEDIS reporting period, the administrative rates calculated by DHS were used for trending and analysis. DHS verified that the

CIS data in the ATR are augmented with data from the Minnesota Immunization Information Connection (MIIC[45]). DHS and IPRO are confident that the CIS rates presented in the ATR are valid.

[45] Minnesota Department of Health Minnesota Immunization Information (MIIC) website: https://www.health.state.mn.us/miic

APPENDIX A – VALIDATION OF PIPS

OBJECTIVES

PIPs are required by federal law for MCOs, which provide healthcare services to Medicaid recipients. These projects are intended to focus on areas of the healthcare system where serious need for improvements exist. The projects must use medically appropriate guidelines and scientifically sound approaches to fix problems.

The current PIPs are focused on addressing the Opioid Crisis. The projects are intended to prevent patients who receive a new opioid prescription from staying on opioid drugs for long periods of time, especially if more effective pain management options are available and appropriate for the patient. The current opioid PIPs run for three years, 2018 through 2020.

TECHNICAL METHODS OF DATA COLLECTION AND ANALYSIS

- The PIP to be conducted over a three year period (calendar years 2018, 2019, and 2020).
- The PIP must be consistent with CMS' published protocol entitled "Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects," STATE requirements, and include steps one through seven of the CMS protocol.
- The MCO shall provide annual PIP progress reports to the STATE.
- The first interim report will be due September 1, 2019.
- The second interim report will be due September 1, 2020.
- For the 2018-2020 PIPs, the final report will be due September 1, 2021.

Process Measures for Consistent Messaging for Community Outreach:

1. Log of locations/organizations receiving educational materials
2. Number of educational materials developed

Process Measures for Targeted Clinic Outreach:

1. Number of clinics identified for joint outreach
2. Number of clinics participating in outreach

DESCRIPTION OF DATA OBTAINED

IPRO received a copy of the Prevention of New Chronic Opioid Use 2018-2020 Performance Improvement Project (Year 1) Report. The report included clinical justification, provider interventions, descriptions of process measures, MCO-level PIP summaries, observed outcomes including data, barriers and conclusions.

APPENDIX B – VALIDATION OF PERFORMANCE MEASURES

DHS-CALCULATED HEDIS PERFORMANCE MEASURES

Objectives

DHS elects to use standardized performance measures to assess quality of care and services provided by its contracted managed care organizations (MCOs). These measures are calculated from encounter data submitted by these organizations to DHS. In order to assure that specifications for these measures are followed, and that DHS' healthcare information system is capable of supporting such measures, DHS contracts with MetaStar for a rigorous assessment each year. This assessment meets the Centers for Medicare & Medicaid Services (CMS) performance measurement validation standards.

The assessment is not intended to evaluate the overall effectiveness of DHS' systems. Rather, the focus is on evaluating aspects of DHS' systems that specifically influence the ability to accurately report performance measures. In essence, DHS needs to demonstrate that it has the automated systems, management practices, data control procedures, and computational procedures necessary to ensure that all performance measure information is adequately captured, transformed, stored, computed, analyzed, and reported.

Technical Methods of Data Collection and Analysis

DHS currently calculates rates for forty-nine (49) performance measures. This set of measures focuses on early detection and management of chronic disease, basic preventive care, and access to care. The measures follow specifications found in the Healthcare Effectiveness Data and Information Set (HEDIS®) 2020 Technical Specifications and the AHRQ Prevention Quality Indicator Technical Specifications. MetaStar's assessment was limited to the thirty-three (33) HEDIS performance measures.

DHS uses those HEDIS measures best suited to available encounter data. Although HEDIS specifications are followed closely for all measures, a few require minor modifications due to state-specific requirements or data idiosyncrasies. In addition to monitoring MCO performance, this set of measures is useful in tracking progress toward internal quality improvement objectives and in meeting other state agency requirements.

To make its assessment, MetaStar examined extensive sets of system documentation and detailed computer program code; conducted interviews with DHS staff; and performed internal data consistency checks and comparative tests of measure results against benchmark data. Any identified system deficiencies or data problems were immediately corrected and reviewed again. The assessment is performed following all processes required by the Balanced Budget Act (BBA) (42 CFR 438.358[b][1]) and CMS Protocol Calculating Performance Measures, Validating Performance Measures, and Appendix Z (ISCAT).

The MetaStar approach included:

- Document review;

- Interviews;
- Operational quality reports; and
- Measure comparisons.

Each approach is capable of uncovering data integrity problems that might threaten the reliability of one or more measures.

MetaStar gathered from DHS a wide range of documentation regarding enrollment and encounter data, including special studies and periodic audits, data correction policies and procedures, issues logs, electronic data interchange (EDI) specifications, staffing levels, size of databases, and uses of these data. These documents were initially collected in the first annual assessment and are updated each year as necessary. To add depth to the information available in the documentation, and to clarify where necessary, MetaStar conducts interviews with those DHS staff responsible for the data systems. MetaStar asks detailed questions to assure that enrollment data are accurately collected and securely maintained.

Enrollment data for Minnesota's publicly funded managed care programs are all maintained at the state level, so performance measurement access to this primary source is direct and relatively simple. Knowledge of its problems is readily available. Encounter data are only as good as what are submitted by the MCO, so robust methods for error detection and correction are necessary. Operational quality reports, such as data error rates and volume discrepancies reports provide MetaStar with quantitative information about problems with encounter submissions and resolutions to those problems.

In addition to documentation review, interviews, and data quality reports, the quality of these data can be assessed in terms of the results they produce. MetaStar has access to a range of MCO, state, and national "benchmarks" against which Minnesota's public program performance measure results are compared. Large discrepancies alert the reviewers to possible underlying data problems.

Description of Data Obtained

IPRO received a copy of the 2019 Performance Measure Validation Report produced by MetaStar. The report included results of the data quality validation and information system validation, detailed assessment of DHS's information system capabilities and results of the measure validation, including rate review and benchmarking.

MCO-Calculated HEDIS Performance Measures

Objectives

The Minnesota Department of Health compiles an annual report using the HEDIS tool to compare how health plans perform in quality of care, access to care, and member satisfaction. The MDH methodology includes hybrid data, which includes medical records reviews.

Technical Methods of Data Collection and Analysis

Due to the COVID-19 outbreak and in accord with NCQA recommendations, DHS and MDH will allow Medicaid health plans to request a waiver to report its audited 2019 HEDIS hybrid rates if they were not able to complete their 2020 hybrid medical record chart reviews according to NCQA specification.

Therefore, those health plans who would like a waiver will need to submit in writing to DHS and MDH a request explaining why the plan is not able to generate its HEDIS 2020 hybrid rates as stipulated in their contracts with DHS.

Description of Data Obtained

IPRO received:

- DHS data for measurement year 2017, 2018 and 2019 in Microsoft Excel files that included the following details: measurement year, measure acronym, program category, MCO name, cohort grouping, numerator, denominator, rate, and lower and upper confidence intervals.
- The MCO 2020 HEDIS MY 2019 Final Audit Reports produced by their respective HEDIS Compliance Auditor.
- Locked Audit Review Tables from the MCOs that reported hybrid rates for MY 2019.

APPENDIX C – REVIEW OF COMPLIANCE WITH MEDICAID AND CHIP MANAGED CARE REGULATIONS

OBJECTIVES

Federal statutes require the Department of Human Services (DHS) to conduct on-site assessments of each contracted Managed Care Organization (MCO) to ensure they meet minimum contractual standards. Beginning in calendar year 2007, during the Minnesota Department of Health's (MDH's) managed care licensing examination (MDH QAE) MDH began collecting (on-behalf of DHS) on-site supplemental compliance information. This information is needed to meet the federal Balanced Budget Act's external quality review regulations and is used by the External Quality Review Organization (EQRO) along with information from other sources to generate a detailed annual technical report (ATR). The ATR is an evaluation of MCO compliance with federal and state quality, timeliness and access to care requirements. The integration of the MDH QA Examination findings along with supplemental information collected by MDH (triennial compliance assessment- TCA) meets the DHS federal requirement.

TECHNICAL METHODS OF DATA COLLECTION AND ANALYSIS

1) DHS and MDH collaborated to redesign the SFY TCA processes, simplifying timelines and corrective action plan submissions, and adding a step to confirm MCO compliance with corrective action plans. The basic operational steps remain the same however; when a TCA corrective action plan is needed, the MCO will submit the TCA Corrective Action Plan to MDH following the MDH corrective action plan submission timelines. When the final QA Examination Report is published, the report will include the final TCA Report. Although the attachment of the final TCA Report to the QA Examination Report is a minor enhancement, this will facilitate greater public transparency and simplify finding information on state managed care compliance activities. Below is an overview of the TCA process steps:
2) The first step in the process is the collection and validation of the compliance information by MDH. MDH's desk review and onsite QA Examination includes the collection and validation of information on supplemental federal and public program compliance requirements. To facilitate this process the MCO is asked to provide documents as requested by MDH.
3) DHS evaluates information collected by MDH to determine if the MCO has "met" or "not met" contract requirements. The MCO will be provided a Preliminary TCA Report to review DHS' initial "met/not met" determinations. At this point, the MCO has an opportunity to refute erroneous information, but may not submit new or additional documentation. Ample time and opportunities are allowed during the QA Examination to submit documents, policies and procedures, or other information to demonstrate compliance. The MCO must refute erroneous TCA finding within 30 days. TCA challenges will be sent by the MCO to MDH. MDH will forward the MCO's TCA rebuttal comments to DHS for consideration.
4) Before making a final determination on "not-met" compliance issues, DHS will consider TCA rebuttal comments by the MCO. DHS will then prepare a final TCA Report that will be sent to MDH and

attached to the final QA Examination Report. As a result of attaching the final TCA Report to the QA Examination Report, greater public transparency will be achieved by not separating compliance information and requiring interested stakeholder to query two state agencies for managed care compliance information.

5) The MCO will submit to MDH a corrective action plan (CAP) to correct not-met determinations. The MCO TCA CAP must be submitted to MDH within 30 days. If the MCO fails to submit a CAP, and/or address contractual obligation compliance issues, then financial penalties will be assessed.
6) During the on-site MDH Mid-cycle QA Exam, MDH will follow-up on TCA not-met issues to ensure the MCO has corrected all issues addressed in the TCA Corrective Action Plan. CAP follow-up findings will be submitted to DHS for review and appropriate action will be initiated by DHS if needed.

Description of Data Obtained

To conduct review, MCO documentation on the following topic areas was considered when determining compliance with the standards:

- QI Program Structure
- Information System
- Utilization Management
    - Ensuring Appropriate Utilization
    - 2019 NCQA Standards and Guidelines
- Special Health Care Needs
- Practice Guidelines
- Annual Quality Assurance Work Plan
- Annual Quality Assessment and Performance Improvement Program Evaluation
- Performance Improvement Projects
- Population Health Management
- Advance Directives
- Subcontractors
    - Written Agreement; Disclosures
    - Exclusions of Individuals and Entities; Confirming Identity

APPENDIX D – ADMINISTRATION OR VALIDATION OF QUALITY OF CARE SURVEYS

OBJECTIVES

DHS periodically assesses the perceptions and experiences of members enrolled in various programs as part of its process for evaluating the quality of health care services provided to adult MCO and FFS members. DHS contracted with HSAG to administer and report the results of the CAHPS® Health Plan Survey. The goal of the CAHPS Health Plan Survey is to provide performance feedback that is actionable and that will aid in improving overall member experience. This report presents the 2020 CAHPS results of adult managed care and FFS members in the following programs: F&C-MA, FFS, MNCare, MSC+, and SNBC.

TECHNICAL METHODS OF DATA COLLECTION AND ANALYSIS

For 2020, a total of 8,988 surveys were completed for MHCP, with a 31.62 percent response rate. This response rate was higher than the national adult Medicaid response rate reported by NCQA for 2019, which was 19.6 percent.

Smaller MCOs where there were not enough program members were combined for the purpose of this survey.

- MinnesotaCare program members were combined for HH, IMCare, PW, and South Country. Of those who responded, Hennepin Health members accounted for 8.1%; IMCare members accounted for 10.5%; PrimeWest Health members accounted for 38.8%; and South Country members accounted for 42.6%.
- MSC+ program members were combined for IMCare, PW, and South Country. Of those who responded, IMCare members accounted for 10.8%; PW members accounted for 46.4%; and South Country members accounted for 42.8%.
- SNBC program members were combined for PW and South Country. Of those who responded, PW members accounted for 43.1% and South Country members accounted for 56.9%.

HSAG considered a survey completed if members answered at least three of the following five questions: 3, 10, 19, 23, and 28. Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (did not meet the eligible criteria), were mentally or physically incapacitated, or had a language barrier. The response rate was calculated using the following formula: Completed Surveys/(Sample Size – Ineligibles).

A "top-level" response was defined as follows:

- "9" or "10" for the global ratings
- "Usually" or "Always" for the Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service composite measures, and the Coordination of Care individual item measure.

DESCRIPTION OF DATA OBTAINED

IPRO received a copy of the HSAG report which included survey results, summary and conclusions, survey instrument, description of methodology, and respondent demographics.

D.16. Sample Collaborative Work Product

A sample collaborative work product is provided following this page.