Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
13.0	**Member Grievance and Appeals Procedures**				
13.0.1	The MCO must have a grievance system that complies with 42 CFR, Part 438, Subpart F. The MCO shall establish and maintain a procedure for the receipt and prompt internal resolution of all grievances and appeals in accordance with all applicable state and federal laws.	**Met:** The policy addresses the requirement by detailing the purpose and objectives of the Plan's appeal and grievance system.	3100.70 Member Appeals Policy	Statement of Objective	Page 1
13.0.2	The MCO's grievance and appeals procedures and any changes thereto must be approved in writing by DHH prior to their implementation and must include at a minimum the requirements set forth in this RFP.	**Met**: Policy 3100.90 Member Grievance on Page 5, the policy states: "Any changes to the grievance process are submitted to the Department of Health and Hospitals (DHH) for approval prior to implementation."	3100.70 Member Appeals Policy	Responsibility	Page 5
13.0.3	The MCO shall refer all MCO members who are dissatisfied with the MCO or its subcontractor in any respect to the MCO's designee authorized to review and respond to grievances and appeals and require corrective action.	**Met:** On page 8, the policy states "Upon receipt of an oral or written grievance, Member Services department will document the grievance in the call system and assign to the Grievance System manager."	3100.90 Member Grievance Policy	Investigation and Documentation	Page 8
13.0.4	The member must exhaust the MCO's internal grievance/appeal procedures prior to accessing the State Fair Hearing process.	**Met:** On page 16, the policy states " The member may request a State fair hearing through Department of Administrative Law (DAL) after the appeal decision. This request must be completed within thirty (30)	3100.70 Member Appeals Policy	Request for State Fair Hearing	Page 16

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		calendar days of Aetna Better Health's adverse appeal decision."			
13.0.5	The MCO shall not create barriers to timely due process. The MCO shall be subject to sanctions if it is determined by DHH that the MCO has created barriers to timely due process, and/or, if ten (10) percent or higher of grievance decisions appealed to the State Fair Hearing level within a twelve (12) month period have been reversed or otherwise resolved in favor of the member. Examples of creating barriers shall include but not be limited to: Including binding arbitration clauses in MCO member choice forms; Labeling complaints as inquiries and funneled into an informal review; Failing to inform members of their due process rights; Failing to log and process grievances and appeals; Failure to issue a proper notice including vague or illegible notices; Failure to inform of continuation of benefits; and Failure to inform of right to State Fair Hearing.	**Met:** Policy 3100.70 page 9 states that the Plan "will not implement barriers to the timely due process of their appeal and will not initiate disenrollment because of the member's attempt to exercise his or her rights under the grievance system." The same language is stated on page 4 in Policy 3100.90	3100.70 Member Appeals Policy 3100.90 Member Grievance Policy	Scope Purpose	Page 9 Page 4
13.1	**Applicable Definition – See Glossary**				
13.2	**General Grievance System Requirement**				
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.	**Met:** Policies 3100.70 page 1 and 3100.90 page 1 both address the requirement by detailing the purpose and objectives of the Plans appeal and grievance system.	3100.70 Member Appeals Policy 3100.90 Member Grievance Policy	Purpose Purpose	Page 1 Page 1
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 a MCO level appeal, and may request a State Fair Hearing, once the MCO's appeals process has been exhausted.	**Met:** Policy 3100.70 page 1 addresses a "member's right to file an appeal stemming from an action issued by the health plan, or any of its providers,	3100.70 Member Appeals Policy 3100.90 Member Grievance Policy	Focus Focus	Page 1 and 4 Page 4

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
		and to describe the steps a member may take to file a request for expedited resolution, standard appeal, or State fair hearing." On page 4, the policy states "A member may file an appeal with Aetna Better Health. An authorized member representative, including a provider, may file an appeal on the member's behalf with the written consent of the member." The same language is stated on page 4 in policy 3100.90.			
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.	**Met:** policy 3100.70 page 4 states "An authorized member representative, including a provider, may file an appeal on the member's behalf with the written consent of the member." Policy 3100.90 page 3: the definition of a grievance includes the statement "Any written or verbal expression of dissatisfaction by a member, member representative or	3100.70 Member Appeals Policy 3100.90 Member Grievance Policy	Focus Focus	Page 4 Page 3

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		provider authorized in writing to act on the member's behalf".			
13.2.3	**Time Limits for Filing** – The member must be allowed thirty (30) calendar days from the date on the MCO's notice of action or inaction to file a grievance or appeal. Within that timeframe the member or a representative acting on their behalf may file an appeal or the provider may file an appeal on behalf of the member, and with the member's written consent.	**Met:** Policy 3100.70 page 4 states "For non-clinically urgent situations, the organization makes decisions within 30 calendar days." Policy 3100.90 page 3: the definition of a grievance includes he statement "Any written or verbal expression of dissatisfaction by a member, member representative or provider authorized in writing to act on the member's behalf".	3100.70 Member Appeals Policy 3100.90 Member Grievance Policy	Definitions: Timelines Definitions: Timelines (ABH gives 90 days)	Page 4 Page 3
13.2.4 13.2.4.1	**Procedures for Filing -** The member may file a grievance either orally or in writing.	**Met:** On page 2, the policy states "Any expression of dissatisfaction to the plan, provider, facility by a member made orally or in writing." One page 3, the definition of a grievance includes the statement "Any written or verbal expression of dissatisfaction by a member, member representative or provider authorized in writing to act on the member's behalf".	3100.90 Member Grievance Policy	Definitions: Complaint Definitions: Grievance	Page 2 Page 3

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
13.2.4.2	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 must be provided upon request of the member. The MCO shall make all forms easily available on the MCO's website.	**Met:** Policy 3100.70 page 4, addresses the requirement. The policy provides a detailed description of the Plan's appeal and grievance system and the State Fair Hearing process as detailed in the Member Handbook. Policy 3100.90 page 5 addresses the member's right to appeal, grievance and a State Fairing as detailed in the Member Handbook. The policy also states that the information is available to the member via the Plan's website. The Plan provided a copy of the State Fair Hearing Form that can be completed by the member or their representative. The form can be submitted via mail or fax and can also be completed online at http://www.adminlaw.state.la.us/HH.htm	3100.70 Member Appeals Policy 3100.90 Member Grievance Policy State Fair Hearing Form	Responsibilities Notifying Members of Grievance Process	Page 4 Page 5 Page 1
13.3	**Grievance/Appeal Records and Report**				
13.3.1	The MCO must maintain records of all grievances and appeals. A copy of grievances logs and records of disposition of appeals shall be retained for six (6) years. If any litigation, claim negotiation,	**Met:** Policy 3100.70, page 10 fully meets the requirement and states that records will be	3100.70 Member Appeals Policy 3100.90 Member Grievance Policy	Scope Investigation and Documentation	Page 10 Page 8

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
	audit, or other action involving the documents or records has been started before the expiration of the six (6) 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 six (6) year period, whichever is later.	retained for 7 years which exceeds the state requirement of 6 years. Policy 3100.90 page 8 meets the requirement and mirrors the language noted in policy 3100.70.			
13.3.2	The MCO shall electronically provide DHH with a monthly report of the grievances/appeals in accordance with the requirements outlined in this RFP, to include, but not be limited to: member's name and Medicaid number, summary of grievances and appeals; date of filing; current status; resolution and resulting corrective action. Reports with personally identifying information redacted will be made available for public inspection.	**Met:** policy 3100.73 pages 1-6 addresses the Plans DHH reporting requirements and on page 3 states that the Plan will "produce the monthly reports and quarterly summaries for DHH that are due the 10th day of the month following the close of the reporting period. State required reports include one (1) or more of the following in the required formats specified by the state: Member Appeal, Member Grievance, State Fair Hearing, External Appeal, Provider Dispute, Provider Grievance, Provider Appeal". Policy 3100.70 page 18 addresses reporting including "Appeals Report(s) to	3100.70 Member Appeals Policy 3100.90 Member Grievance Policy 3100.73 Reporting Process	Reporting Reporting Purpose	Page 18 Page 9 Page 1-6

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
		Department of Health and Hospitals (DHH) in the format specified by Department of Health and Hospitals (DHH)." Policy 3100.90 page 9 addresses reporting including "Grievance Report(s) to DHH in the format specified by Department of Health and Hospitals (DHH)."			
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.	**Met:** On page 13, the policy states that the Plan "will promptly forward any adverse decisions to DHH for further review/action upon request by DHH or the Aetna Better Health member."	3100.70 Member Appeals Policy	Pre-Service / Post-Service Appeals Process	Page 13
13.4	**Handling of Grievances and Appeal**				
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;	**Met:** Policy 3100.70 page 7 states that the Plan "will acknowledge the receipt of standard appeals in writing within three (3) business days after receiving an appeal request." Policy 3100.90 page 8 states "All written member grievances	3100.70 Member Appeals Policy 3100.90 Member Grievance Policy	Responsibilities Acknowledgement of Grievances	Page 7 Page 8

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
		are acknowledged in writing within three (3) business days." Auditors, onsite requested a copy of all letter templates for grievances, prior authorization determinations and appeals. These were provided in the post-onsite documentation submission			
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;	**Met:** Policy 3100.70 page 7 and Policy 3100.90 page 4 - both policies state that the Plan "will 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 Teletypewriting Device for the Deaf/Teletypewriter (TTY/TTD) and interpreter capability."	3100.70 Member Appeals Policy 3100.90 Member Grievance Policy	Scope Focus/Disposition	Page 7 Page 4
13.4.1.3	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; and who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by DHH, in treating the member's	**Met:** policies 3100.70 pages 7-8 and 3100.90 page 4 both fully meet the requirement and discuss in detail the responsibilities of decision makers	3100.70 Member Appeals Policy 3100.90 Member Grievance Policy	Scope Scope	Page 7 Page 4

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(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., and a grievance or appeal that involves clinical issues.	involved with clinical and non-clinical appeals/grievances.			
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 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. No additional enrollee follow-up is required.	**Met:** On page 7, the policy states " Members or their representative may file an appeal either verbally by contacting Aetna Better Health's Member Service department at 1-855-242-0802; LA Relay 7-1-1 or by submitting a request in writing. Unless the member is requesting an expedited appeal resolution, a verbal appeal request must be followed by a written, signed appeal."	3100.70 Member Appeals Policy	Scope	Page 7
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 in the case of expedited resolution).	**Met:** On page 8, the policy states "The member and his or her representative are provided a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. Aetna Better Health will inform the member of the limited time available for presenting evidence and	3100.70 Member Appeals Policy	Scope	Page 8

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
		allegations of fact or law, in person as well as in writing in the case of expedited resolution."			
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.	**Met:** On page 8, the policy states "The member and his or her representative are provided with an 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."	3100.70 Member Appeals Policy	Scope	Page 8
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.	**Met:** On page 8, the policy states "The appeals process will include, as parties to the appeal, the member and his or her representative or the legal representative of a deceased member's estate."	3100.70 Member Appeals Policy	Scope	Page 8
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.	Met: The document contains an in depth description of the Plan's Grievance System training program. During the onsite visit, reviewers will discuss the training process, including whether the	Member Services Grievance System LA DRAFT	All	Page 1-156

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		training has been conducted and the number of staff trained.			
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.	**Met:** On page 6, the policy states "The Grievance System manager is responsible for the management of member appeals; the Grievance System manager reports to the Chief Operating Officer (COO). The Grievance System manager's responsibilities include documenting individual appeals, coordinating resolutions, tracking data and reviewing appeals for trends in quality of care or other service related issues."	3100.70 Member Appeals LA		Page 12
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 in §13.7 of this RFP, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.	**Met:** On page 9, the policy states **"**Any appeal that is not resolved within the stated timeframes will be deemed to have been approved as of the date upon which the final determination should have been made."	3100.70 Member Appeals Policy	Scope	Page 9
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.	**Met:** Policy 3100.70 states "The Member Handbook will include information on appeal procedures and timeframes, including…The procedures for	3100.70 Member Appeals Policy Appeal Decision Letter	Responsibility	Page 4 Pages 1- 2

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		exercising the rights to request a State fair hearing within thirty (30) calendar days from the health plan's appeal decision letter." Page 15 provides details of the information contained in the Written Appeal Decision Letter including "A description of the State Fair Hearing process along with any relevant written procedures." The Plan provided a copy of the Appeal Decision Letter for members, which includes a description of the process to request a hearing and includes a copy of the Request for a State Fair Hearing form.			
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(c) and (d) and Section § 12 of this RFP to ensure ease of understanding.	**Met:** The requirement is met in the policy on page 27 under the section titled Language format and requirements.	AMA 7100.05 Prior Authorization LA	Member Grievance and Appeals	Page 27
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;	**Met:** The requirement is met in the policy on page 27 under the section titled Notice of Action Requirements	AMA 7100.05 Prior Authorization LA	Member Grievance and Appeals	Page 27

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
		subsection titled Language format and requirements.			
13.5.2.2	The reasons for the action;	**Met:** The requirement is met in the policy on page 27 under the section titled Notice of Action Requirements subsection titled Language format and requirements.	AMA 7100.05 Prior Authorization LA	Member Grievance and Appeals	Page 27
13.5.2.3	The member's or the provider's right to file an appeal with the MCO;	**Met:** The requirement is met in the policy on page 27 under the section titled Notice of Action Requirements subsection titled Language format and requirements.	AMA 7100.05 Prior Authorization LA	Member Grievance and Appeals	Page 27
13.5.2.4	The member's right to request a State Fair Hearing, after the MCO's appeal process has been exhausted;	**Met:** The requirement is met in the policy on page 27 under the section titled Notice of Action Requirements subsection titled Language format and requirements.	AMA 7100.05 Prior Authorization LA	Member Grievance and Appeals	Page 27
13.5.2.5	The procedures for exercising the rights specified in this section;	**Met:** The requirement is met in the policy on page 27 under the section titled Notice of Action Requirements subsection titled Language format and requirements.	AMA 7100.05 Prior Authorization LA	Member Grievance and Appeals	Page 27
13.5.2.6	The circumstances under which expedited resolution is available and how to request it; and	**Met:** The requirement is met in the policy on page 27 under the section titled Notice of Action Requirements subsection titled	AMA 7100.05 Prior Authorization LA	Member Grievance and Appeals	Page 27

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		Language format and requirements.			
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.	**Met:** The requirement is met in the policy on page 27 under the section titled Notice of Action Requirements subsection titled Language format and requirements.	AMA 7100.05 Prior Authorization LA	Member Grievance and Appeals	Page 27
13.5.2.8	Oral interpretation is available for all languages and how to access it.	**Met:** The requirement is met in the policy on page 27 under the section titled Notice of Action Requirements subsection titled Language format and requirements.	AMA 7100.05 Prior Authorization LA	Member Grievance and Appeals	Page 27
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, except:	**Met:** The requirement is met in the policy on page 27 under the section titled Notice of Action Requirements subsection titled Language format and requirements.	AMA 7100.05 Prior Authorization LA	Member Grievance and Appeals	Page 27
13.5.3.1.1	The period of advanced notice is shortened to five (5) days if probable member fraud has been verified or by the date of action for the following: • in the death of a recipient; • 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	**Met:** The requirement is met in the policy on page 27 under the section titled Notice of Action Requirements subsection titled Language format and requirements.	AMA 7100.05 Prior Authorization LA	Member Grievance and Appeals	Page 27-28

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	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.				
13.5.3.2	For denial of payment, at the time of any action affecting the claim.	**Met:** The requirement is met in the policy on page 28 under the section titled Notice of Action Requirements subsection titled Language format and requirements.	AMA 7100.05 Prior Authorization LA	Member Grievance and Appeals	Page 28
13.5.3.3	For standard service authorization decisions that deny or limit services, as expeditiously as the 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.	**Met:** The requirement is met in the policy on page 28 under the section titled Notice of Action Requirements subsection titled Language format and requirements.	AMA 7100.05 Prior Authorization LA	Member Grievance and Appeals	Page 28
13.5.3.4	If the MCO extends the timeframe in accordance with above, it must: • 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	**Met:** The requirement is met in the policy on page 28 under the section titled Notice of Action Requirements subsection titled Language format and requirements.	AMA 7100.05 Prior Authorization LA	Member Grievance and Appeals	Page 28

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	as expeditiously as the member's health condition requires and no later than the date the extension expires.				
13.5.3.5	On the date the timeframe for service authorization as specified in § 13.6.3.3 expires. Untimely service authorizations constitute a denial and are thus adverse actions.	**Met:** The requirement is met in the policy on page 28 under the section titled Notice of Action Requirements subsection titled Language format and requirements.	AMA 7100.05 Prior Authorization LA	Member Grievance and Appeals	Page 28
13.5.3.6	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 than seventy-two (72) hours after receipt of the request for service.	**Met:** The requirement is met in the policy on page 28 under the section titled Notice of Action Requirements subsection titled Language format and requirements.	AMA 7100.05 Prior Authorization LA	Member Grievance and Appeals	Page 28
13.5.3.7	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.	**Met:** The requirement is met in the policy on page 28 under the section titled Notice of Action Requirements subsection titled Language format and requirements.	AMA 7100.05 Prior Authorization LA	Member Grievance and Appeals	Page 28
13.5.3.8	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 in below.	**Met:** On page 13, the policy states "The appeal is reviewed, and based on medical necessity, a decision is reached. It is then approved and signed by Aetna Better	3100.70 Member Appeals Policy	Pre-Service / Post-Service Appeals Process	Page 13

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		Health's Senior Medical Director or a physician designee and a written *Appeal Decision Letter* is sent to the member, their representative if designated and practitioner as expeditiously as the member's health requires but not to exceed thirty (30) calendar days of the receipt of a pre-service and post service appeal decision; If the decision is upheld, the *Appeal Decision Letter* explains the next level of appeal, which is the State fair hearing option. State fair hearings are available through the State Agency at the Department of Administrative Law (DAL) at 1-225-342-5800			
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.	**Met:** On page 3, the policy states " For non-clinically urgent situations, the organization makes decisions within ninety (90) calendar days."	3100.90 Member Grievance Policy	Definitions: Timelines	Page 3
13.6.1.2	**Standard Resolution of Appeals -** For standard resolution of an appeal and notice to the affected parties, the timeframe is established	**Met:** On pages 3-4, the policy states "For non-clinically urgent	3100.70 Member Appeals Policy	Definitions: Timelines Scope (re: extensions)	Page 4 Page 9

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	as thirty (30) calendar days from the day the MCO receives the appeal. This timeframe may be extended under § 13.7.2 of this section.	situations, the organization makes decisions within thirty (30) calendar days. For post service payment appeals, the organization makes decisions within thirty (30) calendar days." On page 9, the policy states the Plan "will resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires but will not exceed thirty (30) calendar days from the date the appeal is received for pre-service and post-service appeals."			
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 § 13.6.2 of this Section.	**Met:** On page 4, the policy states " For clinically urgent situations, the organization follows an expedited appeal timeline making decisions within seventy-two (72) hours." On page 9, the policy states that the Plan will "render a decision on the appeal within seventy-two (72) hours. For notice of an expedited resolution,	3100.70 Member Appeals Policy	Definitions: Timelines Scope (re: extensions)	Page 4 Page 9

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		Aetna Better Health will make reasonable effort to provide oral notice within the seventy-two (72) hours and will provide written notice to all parties to the appeal, the member, the practitioner and the representative if designated, as expeditiously as the member's health requires but no later than two (2) business days after the initial oral notification."			
13.6.2	**Extension of Timeframes -** The MCO may extend the timeframes from § 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.	**Met:** On page 9, the policy states that the Plan "may extend the timeframe for standard or expedited resolution of the appeal by up to fourteen (14) calendar days if the member requests the extension; or Aetna Better Health demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's interest."	3100.70 Member Appeals Policy	Scope	Page 9
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.	**Met:** On page 9, the policy states that: "If the resolution timeframe is being extended and was *not* requested by the	3100.70 Member Appeals Policy	Scope	Page 9

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		member, Aetna Better Health must give written notice of the delay within the original thirty (30) calendar days."			
13.6.3 13.6.3.1 13.6.3.2	**Format of Notice of Disposition - Grievances.** DHH will specify the method the MCO will use to notify a 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.	**Met:** On page 9, the policy states that the Plan "will resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires but will not exceed thirty (30) calendar days from the date the appeal is received for pre-service and post-service appeals. For an expedited appeal request, Aetna Better Health notifies the party filing the appeal, as soon as possible of all information that the plan requires to evaluate the appeal. Aetna Better Health will render a decision on the appeal within seventy-two (72) hours. For notice of an expedited resolution, Aetna Better Health will make reasonable effort to provide oral notice within the seventy-two (72) hours and will provide written notice	3100.70 Member Appeals Policy	Scope (re: standard) Scope (re: expedited)	Page 9 Page 9

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		to all parties to the appeal, the member, the practitioner and the representative if designated, as expeditiously as the member's health requires but no later than two (2) business days after the initial oral notification."			
13.6.4 13.6.4.1 13.6.4.2	**Content of Notice of Appeal Resolution -** The written notice of the resolution must include the following: the results of the resolution process 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.	**Met:** Policy 3100.70 on page 15 under section titled Written Appeal Decision Letter fully meets the requirement and contains a line by line description of items that match the requirement.	3100.70 Member Appeals Policy Appeal Decision Letter	Written Appeal Decision Letter (Pre-Service, Expedited, Post-Service)	Page 15 Page 1-2
13.6.5	**Requirements for State Fair Hearings -** The MCO shall comply with all requirements as outlined in this RFP.	**Met:** On page 15, the policy states "The member may request a State Fair Hearing through Department of Administrative Law (DAL) after the appeal decision. This request must be completed within thirty (30) calendar days of Aetna Better Health's adverse appeal decision."	3100.70 Member Appeals Policy	Request for State fair hearing	Page 16
13.6.5.1	**Availability.** If the member has exhausted the MCO level appeal procedures, the member may request a State Fair Hearing within thirty (30) days from the date of the MCO's notice of resolution.	**Met:** On page 15, the policy states "The member may request a State Fair Hearing through Department of	3100.70 Member Appeals Policy	Request for State fair hearing	Page 16

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		Administrative Law (DAL) after the appeal decision. This request must be completed within thirty (30) calendar days of Aetna Better Health's adverse appeal decision."			
13.6.5.2	**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.	**Met:** On page 8, the policy states "The appeals process will include, as parties to the appeal, the member and his or her representative or the legal representative of a deceased member's estate."	3100.70 Member Appeals Policy	Scope	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.	**Met:** On page 9, the policy states that "An expedited review process for appeals will be utilized if it is determined by the health plan, or if the provider indicates (in making the request on the member's behalf) that taking the time for standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function."	3100.70 Member Appeals Policy	Scope	Page 9
13.7.1	**Prohibition Against Punitive Action -** The MCO must ensure that punitive action is not taken against a provider, acting on behalf of the member and with the member's written consent,	**Met:** On page 9, the policy states that " Aetna Better Health will make sure that punitive	3100.70 Member Appeals Policy	Scope	Page 9

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	who requests an expedited resolution or supports a member's appeal.	action is not taken in retaliation against a member who requests an appeal or a provider who requests an expedited resolution or supports a member's appeal. Aetna Better Health will not implement barriers to the timely due process of their appeal and will not initiate disenrollment because of the member's attempt to exercise his or her rights under the grievance system."			
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.	**Met:** On pages 9-10, the policy states that "If a member's request for expedited resolution is denied, the appeal will be transferred to the timeframe for standard resolution and Aetna Better Health will make reasonable efforts to give the member prompt verbal notice of the denial and follow up within two (2) calendar days with a written notice. The written notice will include their rights to request a grievance as applicable." On page 2 of the Appeal Request	3100.70 Member Appeals Policy Exp Appeal Request Denied Letter	Scope	Pages 9- 10 Page 1-2

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		Denied Letter (the example letter notes that a request for an expedited appeal was denied), it states "If you do not agree with this decision to process your appeal taking the usual time frame you may file a grievance with Aetna Better Health. You can request a grievance by phone at **1-855-242-0802** or in writing." The letter provides the contact information and mailing address.			
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. If a determination is not made by the above timeframes, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.	**Met:** On page 9, the policy states **"**Any appeal that is not resolved within the stated timeframes will be deemed to have been approved as of the date upon which the final determination should have been made."	3100.70 Member Appeals Policy	Scope	Page 9
13.7.4 13.7.4.1 13.7.4.2	**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 writing. No additional follow-up may be required. The MCO shall inform the member of the limited time available for the member to present evidence	**Met:** On page 8, the policy states "The member and his or her representative are provided a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. Aetna Better Health will	3100.70 Member Appeals Policy	Scope	Pages 6-7

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	and allegations of fact or law, in person and in writing, in the case of expedited resolution.	inform the member of the limited time available for presenting evidence and allegations of fact or law, in person as well as in writing in the case of expedited resolution."			
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.	**Met:** Policy 3100.70 page 1 addresses the "member's right to file an appeal stemming from an action issued by the health plan, or any of its providers, and to describe the steps a member may take to file a request for expedited resolution, standard appeal, or State fair hearing." On page 4, the policy states "A member may file an appeal with Aetna Better Health. An authorized member representative, including a provider, may file an appeal on the member's behalf with the written consent of the member."	3100.70 Member Appeals Policy	Scope	Page 7
13.7.6	**Format of Resolution Notice –** In addition to written notice, the MCO must also make reasonable effort to provide oral notice.	**Met**: On page 9, the policy states "For notice of an expedited resolution, Aetna Better Health will make reasonable effort to	3100.70 Member Appeals Policy	Scope	Page 9

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		provide oral notice within the seventy-two (72) hours and will provide written notice to all parties to the appeal, the member, the practitioner and the representative if designated, as expeditiously as the member's health requires but no later than two (2) business days after the initial oral notification."			
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; • 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 • the member requests extension of benefits.	**Met:** On page 17, the policy meets the requirement as detailed in the second paragraph under the section titled Request for Continued Benefits During Appeals Process.	3100.70 Member Appeals Policy	Request for Continued Benefits During Appeals Process	Page 17
13.8.3	**Duration of Continued or Reinstated Benefits –** If the MCO continues or reinstates the member's	**Met:** On pages 17-18, the policy meets the	3100.70 Member Appeals Policy	Request for Continued Benefits During Appeals	Page 17

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	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.	requirement as detailed in the third paragraph under the section titled Request for Continued Benefits During Appeals Process.		Process	
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).	**Met**: On page 18, the policy states "If the final resolution of the appeal is adverse to the member, that is, upholds Aetna Better Health 's action, Aetna Better Health 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. The member is informed that he/she can be financial liable for the services that were rendered during this process."	3100.70 Member Appeals Policy	Request for Continued Benefits During Appeals Process	Page 18
13.9	**Information to Providers and Contractors**				
13.9.0	The MCO must provide the information specified	**Met:** The Plan meets	Network Standard Louisiana agreement	Exhibit A in all Templates	Section 4.4

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	at 42 C.F.R. § 438.10(g)(1) about the grievance system to all providers and contractors at the time they enter into a contract.	the contract as noted in all agreements noted in this section (hospital, facility, physician, ancillary and PHO). The wording is identical in 5 agreements as follows: "Grievance System. Company will provide Provider with information regarding Company's grievance system that complies with state and federal laws, including 42 C.F.R. § 438, Subpart F. Provider agrees to adhere to the requirements of Company's grievance and appeals procedures. Provider shall comply with Company's Policies for grievance and appeal procedures as well as facilitate Member grievance and appeals and assist Members as required. No punitive action will be taken against any provider who files on behalf of a Member."	*Located in Provider Network Requirements		Hospital - page 29, Facility Agreement - page 32, Physician group - page 30, Ancillary - page 29, PHO - page 35 Provider - page 32
13.10	**Recordkeeping and Reporting Requirements**				
13.10.0	Reports of grievances and resolutions shall be submitted to DHH as specified in §13.4 and of this RFP. The MCO shall not modify the grievance procedure without the prior written approval of DHH.	**Met:** policy 3100.73 Reporting Process LA pages 1-6 addresses the Plans DHH reporting requirements	3100.90 Member Grievance Policy	Notifying Members of Grievance Process	Page 5

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		and on page 3 states that the Plan will "produce the monthly reports and quarterly summaries for DHH that are due the 10th day of the month following the close of the reporting period. State required reports include one (1) or more of the following in the required formats specified by the state: Member Appeal, Member Grievance, State Fair Hearing, External Appeal, Provider Dispute, Provider Grievance, Provider Appeal". Policy 3100.70 Reporting Process LA page 18 addresses reporting including "Appeals Report(s) to Department of Health and Hospitals (DHH) in the format specified by Department of Health and Hospitals (DHH)." Policy 3100.90 on Page 5, the policy states: "Any changes to the grievance process are submitted to the Department of			

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		Health and Hospitals (DHH) for approval prior to implementation." On page 9, the policy addresses reporting including "Grievance Report(s) to Department of Health and Hospitals (DHH) in the format specified by Department of Health and Hospitals (DHH)."			
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.	**Met:** On page 10, the policy states "If Aetna Better Health or the State Fair Hearing officer reverses the decision to deny, limit or delay services that were not furnished while the appeal was pending, Aetna Better Health will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires."	3100.70 Member Appeals Policy	Responsibility	Page 6
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.	**Met:** On page 10, the policy states "If Aetna Better Health or the State Fair Hearing officer reverses the decision to deny authorization of services, and the member received the disputed services while the appeal was	3100.70 Member Appeals Policy	Responsibility	Page 6

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		pending, Aetna Better Health will pay for those services."			