Contract | RFP Reference	Contract Requirement Language	Review Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
10.1	**Provider Relations**				
10.1	The MCO shall, at a minimum, provide a Provider Relations function to provide support and assistance to all providers in their MCO network, This function shall:	Met This requirement is addressed on page 5 of the Provider Relations Department Functions and Responsibilities Policy.	6200.15 Provider Relations Department Functions and Responsibilities		Page 5
10.1.1	Be available Monday through Friday from 7 am to 7 pm Central Time to address non-emergency provider issues and on a 24/7 basis for non-routine prior authorization requests;	Met This requirement is addressed on page 5 of the Provider Relations Department Functions and Responsibilities Policy.	6200.15 Provider Relations Department Functions and Responsibilities		Page 5
10.1.2	Assure each MCO provider is provided all rights outlined the Provider's Bill of Rights (see Appendix R);	Met This requirement is addressed on page 5 of the Provider Relations Department Functions and Responsibilities Policy.	6200.15 Provider Relations Department Functions and Responsibilities		Page 5
10.1.3	Provide for arrangements to handle emergent provider issues on a 24/7 basis;	Met This requirement is addressed on page 5 of the Provider Relations Department Functions and Responsibilities Policy.	6200.15 Provider Relations Department Functions and Responsibilities		Page 5
10.1.4	Provide ongoing provider training, respond to provider inquiries and provide general assistance to providers regarding program operations and requirements; and	Met This requirement is addressed on page 5 of the Provider Relations Department Functions and Responsibilities Policy.	6200.15 Provider Relations Department Functions and Responsibilities		Page 5
10.1.5	Ensure regularly scheduled visits to provider sites, as well as ad hoc visits as circumstances dictate.	Met This requirement is addressed on page 5 of the Provider	6300.50 Provider Office Visits 6200.15 Provider Relations Department Functions and Responsibilities	Policy	Page 2 Page 5

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		Relations Department Functions and Responsibilities Policy. Additionally, page 2 of the Provider Office Visits Policy states that the Provider Relations Department will ensure that the site visits take place.			
10.2	**Provider Toll-free Telephone Line**				
10.2.1	The MCO must operate a toll-free telephone line to respond to provider questions, comments and inquiries.	Met This requirement is addressed on page 4 of the Provider Toll-Free Help Line Policy.	6200.25 Provider Toll-Free Help Line		Page 4
10.2.2	The provider access component of the toll-free telephone line must be staffed between the hours of 7am -7pm Central Time Monday through Friday to respond to provider questions in all areas, including provider complaints and regarding provider responsibilities. The provider access component must be staffed on a 24/7 basis for prior authorization requests.	Met This requirement is addressed on page 4 of the Provider Toll-Free Help Line Policy.	6200.25 Provider Toll-Free Help Line		Page 4
10.2.3	The MCO's call center system must have the capability to track provider call management metrics.	Met This requirement is addressed on page 7 of the Provider Toll-Free Help Line Policy. Call metrics are located on page 5 of the same policy.	6200.25 Provider Toll-Free Help Line		Page 7
10.2.4	After normal business hours, the provider service component of the toll-free telephone line must include the capability of providing information regarding normal business hours and instructions to verify enrollment for any MCO member with an emergency or urgent medical condition. This shall not be construed to mean that the provider must obtain verification before providing emergency	Met This requirement is addressed on pages 5 and 6 of the Provider Toll-Free Help Line Policy.	6200.25 Provider Toll-Free Help Line		Page 5-6

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	department services and care.				
10.3	**Provider Website**				
10.3.1	The MCO shall have a provider website. The provider website may be developed on a page within the MCO's existing website (such as a portal) to meet these requirements.	Met This requirement is addressed on page 11 of the Provider Relations Department Functions and Responsibilities Policy. This is also addressed on page 8 of the plan's Marketing Plan.	LA Marketing Plan *Located in Marketing section 6200.15 Provider Relations Department Functions and Responsibilities		Page 8 Page 11
10.3.2	The MCO provider website shall include general and up-to-date information about the MCO as it relates to the Louisiana Medicaid program. This shall include, but is not limited to: 10.3.2.1. MCO provider manual; 10.3.2.2. MCO-relevant DHH bulletins; 10.3.2.3. Limitations on provider marketing; 10.3.2.4. Information on upcoming provider trainings; 10.3.2.5. A copy of the provider training manual; 10.3.2.6. Information on the provider grievance system; 10.3.2.7. Information on obtaining prior authorization and referrals; and 10.3.2.8. Information on how to contact the MCO Provider Relations.	Met This requirement is addressed on page 11 of the Provider Relations Department Functions and Responsibilities Policy. This is also addressed on page 9 of the plan's Marketing Plan.	LA Marketing Plan *Located in Marketing section 6200.15 Provider Relations Department Functions and Responsibilities		Page 9 Page 11
10.3.3	The MCO provider website is considered marketing material and, as such, must be reviewed and approved in writing within thirty (30) days of the date the MCO signs the Contract.	Met This requirement is addressed on page 11 of the Provider Relations Department Functions and Responsibilities Policy. This is also addressed on page 9 of the plan's Marketing Plan.	LA Marketing Plan *Located in Marketing section 6200.15 Provider Relations Department Functions and Responsibilities		Page 9 Page 11
10.3.4	The MCO must notify DHH when the provider website is in place.	Met This requirement is	LA Marketing Plan *Located in Marketing section		Page 9

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		addressed on page 9 of the plan's Marketing Plan.			
10.3.5	The MCO must remain compliant with HIPAA privacy and security requirements when providing any member eligibility or member identification information on the website.	Met This requirement is addressed on page 12 of the Provider Relations Department Functions and Responsibilities Policy. It is also addressed on page 9 of the plan's Marketing Policy.	LA Marketing Plan *Located in Marketing section 6200.15 Provider Relations Department Functions and Responsibilities		Page 9 Page 12
10.3.6	The MCO website should, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act, and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern.	Met This requirement is addressed on page 12 of the Provider Relations Department Functions and Responsibilities as well as page 8 of the plan's Marketing Plan.	LA Marketing Plan *Located in Marketing section 6200.15 Provider Relations Department Functions and Responsibilities		Page 8 Page 12
10.4	**Provider Handbook**				
10.4.1	The MCO shall develop and issue a provider handbook within thirty (30) days of the date the MCO signs the Contract with DHH. The MCO may choose not to distribute the provider handbook via surface mail, provided it submits a written notification to all providers that explains how to obtain the provider handbook from the MCO's website. This notification shall also detail how the provider can request a hard copy from the MCO at no charge to the provider. All provider handbooks and bulletins shall be in compliance with state and federal laws. The provider handbook shall serve as a source of information regarding MCO covered services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all MCO requirements are met. At a minimum, the	Met This requirement is addressed on page 3 of the Provider Manual Policy.	6300.15 Provider Manual		Page 3

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	provider handbook shall include the following information:				
10.4.1.1	Description of the MCO;	Met This requirement is addressed on pages 2 through 4 of the Provider Manual. The plan gives a description of the MCO in a section entitled 'Introduction to Aetna Better Health of Louisiana'.	LA Provider Manual		Page 2-4
10.4.1.2	Core benefits and services the MCO must provide;	Met This requirement is addressed on pages 25 through 31 of the Provider Manual under Chapter 5 'Covered and Non-Covered Services'.	LA Provider Manual		Page 25-31
10.4.1.3	Emergency service responsibilities;	Met This requirement is addressed on page 32 of the Provider Manual under 'Emergency Services'.	LA Provider Manual		Page 32
10.4.1.4	Policies and procedures that cover the provider complaint system. This information shall include, but not be limited to, specific instructions regarding how to contact the MCO to file a provider complaint, the timeframes allowed for resolving claims payment issues and the process a provider would take to escalate unresolved issues;	Met This requirement is addressed on pages 62 through 71 of the Provider Manual. Here, the provider is apprised of the plan's Provider Complaint System and the Grievance/Complaint Process.	LA Provider Manual		Page 70-71
10.4.1.5	Information about the MCO's Grievance System, that with written permission from the member, the provider may file a grievance or appeal on behalf of the member, the time frames and requirements,	Met These requirements are addressed on pages 62 through 74 of	LA Provider Manual		Page 62-74

Contract | RFP Reference	Contract Requirement Language	Review Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
	the availability of assistance in filing, the toll-free telephone numbers and the member's right to request continuation of services while undergoing due process in the MCO's appeal process, and any additional information specified in 42 CFR §438.10(g)(1). The member's written approval may be obtained in advance as part of the member intake process.	the Provider Manual. Additionally, the plan provided a Provider Grievances Policy that addresses this contractual requirement.			
10.4.1.6	Medical necessity standards as defined by DHH and practice guidelines;	Met This requirement is addressed on pages 31 and 32 of the Provider Manual.	LA Provider Manual		Page 31-32
10.4.1.7	Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;	Met This requirement is addressed on pages 37 through 39 of the Provider Manual under Chapter 8 'Members With Special Needs'.	LA Provider Manual		Pages 37-39
10.4.1.8	PCP responsibilities;	Met PCP responsibilities are addressed in the Provider Manual on pages 8 through 24.	LA Provider Manual		Pages 8-24
10.4.1.9	Other provider responsibilities under the subcontract with the MCO;	Met On page 8 of the Provider Manual it states that Providers are contractually obligated to adhere to and comply with all terms of the Louisiana Bayou Health Program, the Request for Proposal between DHH and Aetna Better Health and Louisiana, and their Provider Agreement, and requirements outlined	LA Provider Manual		Page 8

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		in the Provider Manual.			
10.4.1.10	Prior authorization and referral procedures;	Met Prior authorization and referral procedures are addressed in Chapter 11 of the Provider Manual on pages 41 through 46.	LA Provider Manual		Pages 41-46
10.4.1.11	Medical records standards;	Met Medical Records standards are addressed in the Provider Manual on pages 17 through 19 under the Section entitled 'Medical Records Review'.	LA Provider Manual		Pages 17-19
10.4.1.12	Claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim and samples of clean and complete claims;	Met Claims submission protocols and standards are addressed in the Provider Manual on pages 53 through 62.	LA Provider Manual		Pages 53-62
10.4.1.13	MCO prompt pay requirements (see Section § 9);	Met This requirement is addressed on page 55 of the Provider Manual under sub-section 'Prompt Payment Requirement'.	LA Provider Manual		Page 55
10.4.1.14	The MCO's chronic care management program;	Met Information regarding the plan's chronic care management program is found on pages 39 and 40 of the Provider Manual under Chapter 9 'Medical Management'.	LA Provider Manual		Pages 39-40
10.4.1.15	Quality performance requirements; and	Met	LA Provider Manual		Pages 46-50

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		This requirement is addressed on pages 46 through 50 of the Provider Manual under Chapter 12 'Quality Management'.			
10.4.1.16	Provider rights and responsibilities.	Met This requirement is addressed on pages 8 through 16 of the Provider Manual.	LA Provider Manual		Pages 8-16
10.4.2	The MCO shall disseminate bulletins as needed to incorporate any changes to the provider handbook.	Met This requirement is addressed on page 4 of the Provider Manual Policy.	6300.15 Provider Manual		Page 4
10.4.3	The MCO shall make available to DHH for approval a provider handbook specific to the Louisiana MCO Program, no later than thirty (30) days prior from the date the MCO signs the Contract with DHH.	Met This requirement is addressed on page 4 of the Provider Manual Policy.	6300.15 Provider Manual		Page 4
10.5	**Provider Education and Training**				
10.5.1	The MCO shall provide training to all providers and their staff regarding the requirements of the Contract, including limitations on provider marketing, and identification of special needs of members. The MCO shall conduct initial training within thirty (30) days of placing a newly contracted provider, or provider group, on active status. The MCO shall also conduct ongoing training, as deemed necessary by the MCO or DHH, in order to ensure compliance with program standards and the Contract.	Met This requirement is addressed on page 5 of the Provider Relations Department Functions and Responsibilities.	6200.15 Provider Relations Department Functions and Responsibilities		Page 5
10.5.2	The MCO shall submit a copy of the Provider Training Manual and training schedule to DHH for approval within thirty (30) calendar days of the date the MCO signs the Contract with DHH. Any changes to the manual shall be submitted to DHH at least thirty (30) calendar days prior to the scheduled change and dissemination of such	Met This requirement is addressed on page 5 of the Provider Relations Department Functions and Responsibilities.	6200.15 Provider Relations Department Functions and Responsibilities		Page 5

Contract | RFP Reference	Contract Requirement Language	Review Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
	change.				
10.5.3	The MCO shall develop and offer specialized initial and ongoing training in the areas including but not limited to billing procedures and service authorization requirements for network providers who have traditionally billed and obtained service authorization primarily from Medicaid and/or Medicare only. This includes but is not limited to personal care services providers and hospice providers and may include other provider types at the discretion of DHH.	Met The plan provided a document entitled PS_Agenda which is an agenda of the training provided to new hires by Provider Services. The plan submitted a sample training presentation for providers that describes billing procedures and service authorization requirements.	LA_PS_Agenda.doc Provider Training PPT Training Presentation SAMPLE *Note: The submitted training is a sample from another state. The training for Louisiana is in development.		Page 3,4 Entire Document
10.6	**Provider Complaint System**				
10.6.1 10.6.1.1 10.6.1.2	Applicable Definitions Definition of Provider Complaint For the purposes of this subsection, a provider complaint is any verbal or written expression, originating from a provider and delivered to any employee of the MCO, voicing dissatisfaction with a policy, procedure, payment or any other communication or action by the MCO, excluding request of reconsideration or appeal for specific individual claims. It does include general complaints about claim payment policies. Definition of Action For the purposes of this subsection an action is defined as: The denial or limited authorization of a requested service, include the type or level of service; or the reduction, suspension, or termination of a previously authorized service; or the failure to provide services in a timely manner, as defined in Section §7.3 and Section §7.5 of this RFP; or the failure of the MCO to act within the	Met The definition of Provider Complaint is delineated in the Provider Grievances Policy on pages 1 and 2. The definition of 'Action' is contained on page 1 of the Provider Appeals Policy.	6300.35 Provider Grievances Policy 6300.38 Provider Appeals Policy	Definitions: Grievance Definitions: Appeal	Page 1 and 2 Page 1

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	timeframes provided in Section §13.7.1 of this RFP.				
10.6.2	The MCO shall establish a Provider Complaint System with which to track the receipt and resolution of provider complaints from in-network and out-of-network providers.	Met The Provider Grievance Policy (page 3) and the Provider Appeals Policy define the Provider Complaint System as the process in which the provider is able to file a complaint, grievance or appeal and the system for documenting and tracking complaints, grievances and appeals and their resolutions (page 2). Both policies discuss the implementation of a system that will track the receipt and resolution of provider complaints.	6300.35 Provider Grievances Policy 6300.38 Provider Appeals Policy	Definitions: Provider Complaint System Definitions: Provider Complaint System	Page 3 Page 2
10.6.3	This system must be capable of identifying and tracking complaints received by phone, in writing, or in person, on any issue that expresses dissatisfaction with a policy, procedure, or any other communication or action by the MCO.	Met The Provider Grievance Policy addressed this requirement on pages 3 and 4.	6300.35 Provider Grievances Policy 6300.38 Provider Appeals Policy	Definitions: Provider Complaint System Definitions: Appeals and Grievance Database	Page 3 Page 1
10.6.4	As part of the Provider Complaint system, the MCO shall:				
10.6.4.1	Have dedicated provider relations staff for providers to contact via telephone, electronic mail, surface mail, and in person, to ask questions, file a provider complaint and resolve problems;	Met This requirement is addressed on page 4 of the Provider Grievances Policy and on page 3 of the Provider Appeals Policy.	6300.35 Provider Grievances Policy 6300.38 Provider Appeals Policy	Scope Responsibility	Page 4 Page 3

Contract | RFP Reference	Contract Requirement Language	Review Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
10.6.4.2	Identify a key staff person specifically designated to receive and process provider complaints;	Met The Provider Grievance Policy (page 4) identifies the Grievance System Manager as the key staff person specifically designated to receive and process provider grievances and to consolidate complaints. It is worth noting that the plan defines complaints as 'any issue of dissatisfaction'. The plan defines grievances as 'any written or verbal expression of dissatisfaction by a provider, including complaints'.	6300.35 Provider Grievances Policy 6300.38 Provider Appeals Policy	Scope Responsibility	Page 4 Page 3
10.6.4.3	Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from all parties and applying the MCO's written policies and procedures; and	Met This requirement is addressed on page 4 of the Provider Grievances Policy and on page 6 of the Provider Appeals Policy.	6300.35 Provider Grievances Policy 6300.38 Provider Appeals Policy	Scope Scope	Page 4 Page 6
10.6.4.4	Ensure that MCO executives with the authority to require corrective action are involved in the provider complaint escalation process, provide names, phone numbers and email addresses to DHH within one (1) week of contract approval and within two (2) business days of any changes.	Met Page 4 of the Provider Grievances Policy addresses the requirement that the plan's executives, with the authority to require corrective action, are involved in the provider	6300.35 Provider Grievances Policy	Scope	Page 4 and 7

Contract | RFP Reference	Contract Requirement Language	Review Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
		complaint process. Page 7 of the Provider Grievances Policy addresses the requirement that the plan provide names, phone numbers and email addresses to DHH within one (1) week of the contract approval and within two (2) business days of any changes.			
10.6.5	The MCO shall have and implement written policies and procedures which detail the operation of the Provider Complaint System. The MCO shall submit its Provider Complaint System policies and procedures to DHH for review and approval within thirty (30) Calendar Days of the date the Contract with DHH is signed. Note that provider complaints must be acknowledged within 3 business days. They should be resolved as soon as feasible, but within no more than 30 calendar days; unless both the provider and DHH has been notified of the outstanding issues, including a timeline for resolution and reason for the extension of time. All complaints should be resolved in no more that 90 days. The policies and procedures shall include, at a minimum:	Met This requirement is addressed in the Provider Grievances Policy on pages 1 through 8. Specifically, the requirement that the plan submit its policy to DHH for review and approval within 30 Calendar days of the date of the contract is on page 6. The requirement that provider complaints be acknowledged within 3 business days is on page 5. The remainder of the requirement pertaining to the resolution of the complaint and its respective timeframes is found on page 4.	6300.35 Provider Grievances Policy 6300.38 Provider Appeals Policy 6300.00 Provider Dispute Resolution Policy	All All All	Pages 1-8 Pages 1-8 Pages 1-5

Contract | RFP Reference	Contract Requirement Language	Review Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
10.6.5.1	Allowing providers thirty (30) days to file a written complaint and a description of how providers file complaint with the MCO and the resolution time;	Met This requirement is addressed on page 5 of the Provider Grievance Policy and on page 3 of the Provider Appeals Policy.	6300.35 Provider Grievances Policy 6300.38 Provider Appeals Policy	Scope Responsibility	Page 5 Page 3
10.6.5.2	A description of how and under what circumstances providers are advised that they may file a complaint with the MCO for issues that are MCO Provider Complaints and under what circumstances a provider may file a complaint directly to DHH/MMIS for those decisions that are not a unique function of the MCO;	Met The Provider Grievances Policy, pages 5 and 7, and the Provider Appeals Policy, page 4, describe how providers are advised that they may file a complaint with the plan and under what circumstances. The updated policy submitted post-onsite includes information advising the providers of the circumstances under which they may file a complaint directly to DHH/MMIS for those decisions that are not a unique function of the plan.	6300.35 Provider Grievances Policy 6300.38 Provider Appeals Policy	Responsibility Request Appeal to State Agency Scope	Pages 5 and 7 Page 4
10.6.5.3	A description of how provider relations staff are trained to distinguish between a provider complaint and an enrollee grievance or appeal in which the provider is acting on the enrollee's behalf;	Met The Provider Appeals Policy describes on page 4 that the Provider Services staff as well as the Member Services staff receive appeals and grievance training upon employment with Aetna	6300.35 Provider Grievances Policy 6300.38 Provider Appeals Policy	Scope Scope	Page 6 Page 4

Contract | RFP Reference	Contract Requirement Language	Review Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
		Better Health to include the difference between a provider appeal and a provider submitting a member appeal on behalf of a member.			
10.6.5.4	A process to allow providers to consolidate complaints of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint;	Met Page 6 of the Provider Grievances Policy includes a description of how providers are allowed to consolidate complaints of multiple claims that involve the same or similar payment or coverage issues. The Provider Complaint System flowchart provides an overview of the complaint, grievance and appeals process.	6300.35 Provider Grievances Policy 6300.00F 6300.35F 6300.38F Provider Complaint System LA	Scope 	Page 6 Page 1
10.6.5.5	A process for thoroughly investigating each complaint and for collecting pertinent facts from all parties during the investigation.	Met The Provider Grievances Policy (page 6) and the Provider Appeals Policy (page 7) describes the process for investigating each complaint and also for collecting relevant information.	6300.35 Provider Grievances Policy 6300.38 Provider Appeals Policy	Scope Scope	Page 6 Page 7
10.6.5.6	A description of the methods used to ensure that MCO executive staff with the authority to require corrective action are involved in the complaint process, as necessary;	Met The Provider Grievance Policy (page 6) and the Provider Appeals Policy (page 7) address this	6300.35 Provider Grievances Policy 6300.38 Provider Appeals Policy	Scope Scope	Page 6 Page 7

Contract | RFP Reference	Contract Requirement Language	Review Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
		requirement. Membership on the Grievance Committee is defined in the Quality Program Description and includes the Chief Operating Officer (COO) or their designee and the compliance officer who maintains oversight. Both the COO and Compliance Officer have the authority to require corrective action.			
10.6.5.7	A process for giving providers (or their representatives) the opportunity to present their cases in person;	Met This requirement is addressed on page 5 of the Provider Appeals Policy.	6300.35 Provider Grievances Policy 6300.38 Provider Appeals Policy	Scope Scope	Page 6 Page 5
10.6.5.8	Identification of specific individuals who have authority to administer the provider complaint process;	Met This requirement is addressed on page 6 of the Provider Grievances Policy and on page 4 of the Provider Appeals Policy.	6300.35 Provider Grievances Policy 6300.38 Provider Appeals Policy	Scope Responsibility	Page 6 Page 4
10.6.5.9	A system to capture, track, and report the status and resolution of all provider complaints, including all associated documentation. This system must capture and track all provider complaints, whether received by telephone, in person, or in writing; and	Met This requirement is addressed in the Provider Grievances Policy at page 5 and in the Provider Appeals Policy at page 1. Both documents describe the Appeals and Grievances	6300.35 Provider Grievances Policy 6300.38 Provider Appeals Policy	Definitions: Appeals and Grievance Database Responsibilities	Page 5 Page 1

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		Database and its tracking, trending, review, referral, resolution and reporting functions.			
10.6.5.10	A provision requiring the MCO to report the status of all provider complaints and their resolution to DHH on a monthly basis in the format required by DHH.	Met This requirement is addressed on page 3 of the Reporting Policy.	3100.73 Reporting Policy *Located in Member Grievances & Appeals Procedures section	All	Page 3
10.6.6	The MCO shall include a description of the Provider Complaint System in the Provider Handbook and include specific instructions regarding how to contact the MCOs Provider Relations staff; and contact information for the person from the MCO who receives and processes provider complaints.	Met This requirement is addressed on page 66 of the Provider Manual which includes a description of the Provider Complaint System within a section entitled Provider Grievance System. This section also contains instructions on how to contact the plan's provider relations staff and contact information for the plan.	LA Provider Manual	Provider Grievance System	Page 66
10.6.7	The MCO shall distribute the MCO's policies and procedures to in-network providers at time of subcontract and to out-of-network providers with the remittance advice (RA). The MCO may distribute a summary of these policies and procedures to providers if the summary includes information about how the provider may access the full policies and procedures on the MCO's website. This summary shall also detail how the in-network provider can request a hard copy from the MCO at no charge to the provider.	Met This requirement is addressed on page 5 of the Provider Grievance Policy and page 4 of the Provider Appeals Policy.	6300.35 Provider Grievances Policy 6300.38 Provider Appeals Policy	Responsibility Scope	Page 5 Page 4