Contract | RFP Reference	Contract Requirement Language	Review Determination	MCO Documentation Title(s)	MCO Policy / Procedure / Document Section(s) / Number(s)	MCO Page Number(s)
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 DHH for written approval within thirty (30) days from the date the Contract is signed, annually thereafter, and prior to any revisions.	Met Addressed in AMA 7100.05 Prior Authorization LA policy. The policy includes expedited, concurrent and post-service reviews and authorizations.	AMA 7100.05 Prior Authorization LA	Reporting	Page 30
8.1.2 8.1.2.1 8.1.2.2 8.1.2.3 8.1.2.4	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 a contracting health care professionals; 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; 8.1.2.3. Are consider the needs of the members; and 8.1.2.4. Are reviewed annually and updated periodically as appropriate.	Met Addressed in AMA 7000.30 Approval Process of Medical Necessity Criteria LA policy.	AMA 7000.30 Approval Process of Medical Necessity Criteria LA	Statement of Objective	Page 1
8.1.3	The policies and procedures shall included, 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;	Met In general, the Utilization Management Plan p. 5 contains only the contract language. Documentation found in support of the contract requirement is cited by reviewer throughout this form. Addressed in Utilization Management Plan, titled Aetna Better Health of Louisiana Utilization Management Program Description (p. 5 and Processes	Utilization Management Plan	Program Objectives	Page 5

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		p. 26-42).			
8.1.3.2	The data sources and clinical review criteria used in decision making;	Met Addressed in Utilization Management Plan (p. 5 and Processes p. 27 and 30).	Utilization Management Plan	Program Objectives	Page 5
8.1.3.3	The appropriateness of clinical review shall be fully documented;	Met Addressed in Utilization Management Plan (p. 5 and Processes/Documentation p. 30).	Utilization Management Plan	Program Objectives	Page 5
8.1.3.4	The process for conducting informal reconsiderations for adverse determinations;	Met Addressed in Utilization Management Plan (p. 5 and Processes/Informal Reconsideration Process p. 34).	Utilization Management Plan	Program Objectives	Page 5
8.1.3.5	Mechanisms to ensure consistent application of review criteria and compatible decisions;	Met Addressed in Utilization Management Plan (p. 5 and Processes/Inter-rater Reliability p. 44).	Utilization Management Plan	Program Objectives	Page 5
8.1.3.6	Data collection processes and analytical methods used in assessing utilization of health care services; and	Met Addressed throughout Utilization Management Plan (p. 5 and notably p. 35 and 40).	Utilization Management Plan	Program Objectives	Page 5
8.1.3.7	Provisions for assuring confidentiality of clinical and proprietary information.	Met Addressed in Utilization Management Plan (p. 5 and Processes/Confidentiality p. 46-47).	Utilization Management Plan	Program Objectives	Page 5
8.1.4	The MCO shall coordinate the development of clinical practice guidelines with other DHH MCOs to avoid providers receiving conflicting practice guidelines from different MCOs.	Met In general, the Approval Process of Medical Necessity Criteria LA policy p. 4-5 contains only the contract language. Documentation found in support of the contract requirement is cited by reviewer throughout this form. Guideline development addressed throughout Approval Process of Medical Necessity	AMA 7000.30 Approval Process of Medical Necessity Criteria LA	Responsibilities	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)
		Criteria LA policy and in Utilization Management Plan (Processes/ Clinical Practice Guidelines p. 28). Nationally recognized standards, evidence, expert consensus as well as community-based guidelines are used. CPG examples could be given.			
8.1.5	The MCO shall disseminate the practice guidelines to all affected providers and, upon request, to members and potential members.	Met Addressed in Approval Process of Medical Necessity Criteria LA policy and Utilization Management Plan (Processes/Criteria p. 28).	AMA 7000.30 Approval Process of Medical Necessity Criteria LA	Responsibilities	Page 5
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:	Met Addressed in AMA 7000.30 Approval Process of Medical Necessity Criteria LA policy and Utilization Management Plan (Processes/Criteria p. 27-28). Milliman Care Guidelines, Aetna Policy Bulletins and Aetna Clinical Policy Council Review are used – with LOCUS/CASII and the American Society of Addiction Medicine for behavioral health services.	AMA 7000.30 Approval Process of Medical Necessity Criteria LA	Responsibilities	Page 4
8.1.6.1	The vendor must be identified if the criteria was purchased;	Met In Approval Process of Medical Necessity Criteria LA, Section Protocol/Operating Systems (p. 6), Milliman Care Guidelines application is bulleted. An application vendor is not identified. Addressed in the updated policy	AMA 7000.30 Approval Process of Medical Necessity Criteria LA	Responsibilities	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)
		Approval Process of Medical Necessity Criteria LA (p. 4).			
8.1.6.2	The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state health care provider association or society;	Met Addressed in Approval Process of Medical Necessity Criteria LA policy and Utilization Management Plan (Objectives p. 6). Policies and procedures are developed in accordance with nationally established utilization management guidelines including those of NCQA. MM examples as above.	AMA 7000.30 Approval Process of Medical Necessity Criteria LA	Responsibilities	Page 4
8.1.6.3	The guideline source must be identified if the criteria are based on national best practice guidelines; and	Met Addressed in Approval Process of Medical Necessity Criteria LA policy.	AMA 7000.30 Approval Process of Medical Necessity Criteria LA	Responsibilities	Page 4
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.	Met Addressed in Utilization Management Plan (Program Resources/Chief Medical Officer and Utilization Management Department p. 23-25). Individuals who will make medical necessity determinations are identified by title and qualifications, and not yet identified by name.	AMA 7000.30 Approval Process of Medical Necessity Criteria LA	Responsibilities	Page 5
8.1.7	UM Program medical management criteria and practice guidelines shall be disseminated to all affected providers, members and potential members upon request. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.	Met Dissemination: Addressed in Approval Process of Medical Necessity Criteria LA policy and Utilization Management Plan (Processes/Criteria p. 28). Integration:	AMA 7000.30 Approval Process of Medical Necessity Criteria LA	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)
		Addressed in Approval Process of Medical Necessity Criteria LA policy and Utilization Management Plan (Scope p. 28, Processes/Clinical Practice Guidelines p. 29).			
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.	Met Approval Process of Medical Necessity Criteria LA policy contains only the contract language. The Utilization Management Plan (Processes p. 26) lists information in enrollee record. The Prior Authorization LA policy (p 23-24) addresses extension processes and the need for additional information. The policy includes expedited, concurrent and post-service reviews and authorizations.	AMA 7000.30 Approval Process of Medical Necessity Criteria LA	Responsibilities	Page 4
8.1.9	The MCO shall have written procedures to address the failure or inability of a provider or member to 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.	Met Prior Authorization LA (p. 1) contains only the contract language; (p. 15) states financial penalties will be imposed, or if the service was performed, payment will be denied. Utilization Management Plan (Processes/Lack of Information p. 33) states authorizations will be completed based on the information available at the time of determination within the appropriate timeframe.	AMA 7100.05 Prior Authorization LA	Statement of Objective	Page 1
8.1.10	The MCO shall have sufficient staff with clinical expertise and training to apply service	Met Approval Process of Medical	AMA 7000.30 Approval Process of Medical Necessity Criteria LA	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)
	authorization medical management criteria and practice guidelines.	Necessity Criteria LA (p. 5) contains only the contract language. Prior Authorization LA (p. 12-13) also contains the contract language and addresses the qualifications of staff at a high level, but does not provide details, such as type of licensure required or numbers of licensed/certified staff. The Utilization Management Plan (Resources p. 23) provides more detail regarding qualifications, but not numbers of staff. Addressed in the updated policy Approval Process of Medical Necessity Criteria LA (p. 4).	AMA 7100.05 Prior Authorization LA	Responsibility	Page 13
8.1.11	The MCO shall use DHH'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.	Met Prior Authorization LA (p. 5) contains the contract language and details determinations consistent with the State's definition.	AMA 7000.30 Approval Process of Medical Necessity Criteria LA AMA 7100.05 Prior Authorization LA	Responsibilities Definitions	Page 4 Page 5
8.1.12 8.1.12.1 8.1.12.2 8.1.12.3	The MCO shall submit written policies and procedures for DHH approval, within thirty (30) days of the contract being signed by the MCO, addressing how the core benefits and services ensure: 8.1.12.1. The prevention, diagnosis, and treatment of health impairments. 8.1.12.2. The ability to achieve age-appropriate growth and development and 8.1.12.3. The ability to attain, maintain, or regain functional capacity.	Met Approval Process of Medical Necessity Criteria LA (p. 1) states the policy objectives are to address how the core benefits and services ensure: 8.1.12.1 contract language, 8.1.12.2 contract language, and 8.1.12.3 contract language. The requirements are not addressed in the remaining body of the policy.	AMA 7000.30 Approval Process of Medical Necessity Criteria LA	Statement of Objective	Page 5

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		Prior Authorization LA (p. 30) addresses submission of policies and procedures to the DHH for approval within 30 days of contract signature. The updated policy Approval Process of Medical Necessity Criteria LA (p. 5) states "The core benefits and services ensure the prevention, diagnosis, and treatment of health impairments, the ability to achieve age-appropriate growth and development and the ability to attain, maintain, or regain functional capacity" which is a restatement of the contract language. Updated Policy L83000.05' describes the plan's Prevention and Wellness Program whose purpose is to educate and inform members, practitioners and providers about practices and services that promote good health and encourage members to use available health promotion, health education, and preventive health services. The plan should cite how the core benefits and services ensure these requirements, for example, through preventive services, chronic care management, and EPSDT benefits.			
8.1.13	The MCO must identify the qualification of staff who will determine medical necessity.	Met Approval Process of Medical Necessity Criteria LA and Prior	AMA 7000.30 Approval Process of Medical Necessity Criteria LA	Responsibilities	Page 5

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		Authorization LA (both p. 5) contain only contract language. Actual qualifications are given in Utilization Management Plan (Resources/Chief Medical Officer and UM Department p. 23-25).	AMA 7100.05 Prior Authorization LA	Definitions	Page 5
8.1.14	Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.	Met Approval Process of Medical Necessity Criteria LA (p.5) and Prior Authorization LA (p. 13) contain only contract language. Actual qualifications are given in Utilization Management Plan (Resources/Chief Medical Officer and UM Department p. 23-25).	AMA 7000.30 Approval Process of Medical Necessity Criteria LA AMA 7100.05 Prior Authorization LA	Responsibilities Definitions	Page 5 Page 13
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.	Met Addressed in Approval Process of Medical Necessity Criteria LA (p.5) and Prior Authorization LA (p. 8). The plan could address the use of specialty consultants.	AMA 7000.30 Approval Process of Medical Necessity Criteria LA AMA 7100.05 Prior Authorization LA	Responsibilities focus/disposition	Page 5 Page 8
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 or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.	Met Addressed in Approval Process of Medical Necessity Criteria LA (p.5) and Prior Authorization LA (p. 8).	AMA 7000.30 Approval Process of Medical Necessity Criteria LA AMA 7100.05 Prior Authorization LA	Responsibilities focus/disposition	Page 5 Page 8
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.	Met Addressed in Approval Process of Medical Necessity Criteria LA (p.5) and Prior Authorization LA (p. 8).	AMA 7000.30 Approval Process of Medical Necessity Criteria LA AMA 7100.05 Prior Authorization LA	Responsibilities focus/disposition	Page 5 Page 8
8.1.18	The MCO shall provide a mechanism to reduce	Met	AMA 7100.05 Prior Authorization LA	Statement of Objective	Page 2

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	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.	Addressed in Prior Authorization LA. Mechanisms addressed throughout Statement of Objective (p. 1-2).			
8.1.19	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.	Met Addressed in Prior Authorization LA (p. 2), and throughout Utilization Management Plan (Objective p. 6, Resources/UM Department p.25, Processes/UM Decisions p. 47).	AMA 7100.05 Prior Authorization LA	Statement of Objective	Page 2
8.1.20	The MCO shall report fraud and abuse information identified through the UM program to DHH in accordance with 42 CFR §455.1(a)(1).	Met Addressed in Utilization Management Plan (Structure/Compliance Committee p. 21).	Utilization Management Plan	Compliance Committee/Major responsibilities	Page 21
8.1.21	In accordance with 42 CFR §§456.111 and 456.211, the MCO Utilization Review (UR) plan must provide that each enrollee's record includes information needed for the UR committee to perform UR required under this section. This information must include, at least, the following:	Met Addressed in Utilization Management Plan (Processes p. 26).	Utilization Management Plan	UTILIZATION MANAGEMENT PROCESSES	Page 26
8.1.21.1	Identification of the enrollee;	Met Addressed in Utilization Management Plan (Processes p. 26).	Utilization Management Plan	UTILIZATION MANAGEMENT PROCESSES	Page 26

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8.1.21.2	The name of the enrollee's physician;	Met Addressed in Utilization Management Plan (Processes p. 26).	Utilization Management Plan	UTILIZATION MANAGEMENT PROCESSES	Page 26
8.1.21.3	Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission;	Met Addressed in Utilization Management Plan (Processes p. 26).	Utilization Management Plan	UTILIZATION MANAGEMENT PROCESSES	Page 26
8.1.21.4	The plan of care required under 42 CFR §456.80 and §456.180;	Met Addressed in Utilization Management Plan (Processes p. 26).	Utilization Management Plan	UTILIZATION MANAGEMENT PROCESSES	Page 26
8.1.21.5	Initial and subsequent continued stay review dates described under 42 CFR §§456.128, 456.133; 456.233 and 456.234;	Met Addressed in Utilization Management Plan (Processes p. 26).	Utilization Management Plan	UTILIZATION MANAGEMENT PROCESSES	Page 26
8.1.21.6	Date of operating room reservation, if applicable;	Met Addressed in Utilization Management Plan (Processes p. 26).	Utilization Management Plan	UTILIZATION MANAGEMENT PROCESSES	Page 26
8.1.21.7	Justification of emergency admission, if applicable.	Met Addressed in Utilization Management Plan (Processes p. 26).	Utilization Management Plan	UTILIZATION MANAGEMENT PROCESSES	Page 26
8.2	**Utilization Management Committee**				
8.2.1	The UM program shall include a Utilization Management (UM) Committee that integrates with other functional units of the MCO as appropriate and supports the QAPI Program (refer to the Quality Management subsection for details regarding the QAPI Program).	Met Addressed in QAPI Program Description (QM/UM Committee p. 16-18).	QAPI Program Description *Located in Quality Management section		Page 16
8.2.2	The UM Committee shall provide utilization review and monitoring of UM activities of both the MCO and its providers and is directed by the MCO Medical Director. The UM Committee shall convene no less than quarterly and shall make meeting minutes available to DHH upon request. UM Committee responsibilities include:	Met Addressed in QAPI Program Description (QM/UM Committee p. 16-18).	QAPI Program Description *Located in Quality Management section		Page 16, 18
8.2.2.1	Monitoring providers' requests for rendering	Met	QAPI Program Description		Page 17-18

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	healthcare services to its members;	Addressed in QAPI Program Description (QM/UM Committee p. 17).	*Located in Quality Management section		
8.2.2.2	Monitoring the medical appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling;	Met Addressed in QAPI Program Description (QM/UM Committee p. 17).	QAPI Program Description *Located in Quality Management section		Page 17-18
8.2.2.3	Reviewing the effectiveness of the utilization review process and making changes to the process as needed;	Met Addressed in QAPI Program Description (QM/UM Committee p. 17).	QAPI Program Description *Located in Quality Management section		Page 17-18
8.2.2.4	Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task;	Met Addressed in QAPI Program Description (QM/UM Committee p. 17).	QAPI Program Description *Located in Quality Management section		Page 17-18
8.2.2.5	Monitoring consistent application of "medical necessity" criteria;	Met Addressed in QAPI Program Description (QM/UM Committee p. 17).	QAPI Program Description *Located in Quality Management section		Page 17-18
8.2.2.6	Application of clinical practice guidelines;	Met Addressed in QAPI Program Description (QM/UM Committee p. 17).	QAPI Program Description *Located in Quality Management section		Page 17-18
8.2.2.7	Monitoring over- and under-utilization;	Met Addressed in QAPI Program Description (QM/UM Committee p. 17).	QAPI Program Description *Located in Quality Management section		Page 17-18
8.2.2.8	Review of outliers, and	Met Addressed in QAPI Program Description (QM/UM Committee p. 17).	QAPI Program Description *Located in Quality Management section		Page 17-18
8.2.2.9	**Medical Record Reviews -** reviews of member medical records shall be conducted to ensure that PCPs provide high quality health care that is documented according to established standards. **Medical Record Review Strategy** The MCO shall maintain a written strategy for conducting medical record reviews, reporting results and the corrective action process. The	Met Addressed throughout Review of Practitioner Office Medical Records and MRR Assessment Tool.	QAPI Program Description *Located in Quality Management section 8000.30 Review of Practitioner Office Medical Records *Located in Fraud, Abuse, Waste Prevention section		Page 51 Page 2, 3

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	strategy shall be provided within thirty (30) days from the date the Contract is signed and annually thereafter. The strategy shall include, at a minimum, the following: Designated staff to perform this duty; The method of case selection; The anticipated number of reviews by practice site; The tool the MCO shall use to review each site; and How the MCO shall link the information compiled during the review to other MCO functions (e.g. QI, credentialing, peer review, etc.) The standards, which shall include all medical record documentation requirements addressed in the Contract, shall be distributed to all providers.				
8.2.3	The MCO shall conduct reviews at all PCP sites with fifty (50) or more linked members and practice sites which include both individual offices and large group facilities. The MCO shall review each site at least one (1) time during each two (2) year period.	Met Addressed in Review of Practitioner Office Medical Records and MRR Assessment Tool (p. 4).	QAPI Program Description *Located in Quality Management section 8000.30 Review of Practitioner Office Medical Records *Located in Fraud, Abuse, Waste Prevention section		Page 51 Page 4
8.2.4	The MCO shall review a reasonable number of records at each site to determine compliance. Five (5) to ten (10) records per site is a generally accepted target. For large group practices (six or more providers in the group), three record reviews per provider shall be required.	Met Addressed in Review of Practitioner Office Medical Records and MRR Assessment Tool (p. 3).	QAPI Program Description *Located in Quality Management section 8000.30 Review of Practitioner Office Medical Records *Located in Fraud, Abuse, Waste Prevention section		Page 52 Page 3
8.2.5	The MCO shall report the results of all medical record reviews to DHH quarterly with an annual summary.	Met Addressed in Review of Practitioner Office Medical Records and MRR Assessment Tool (p. 6).	QAPI Program Description *Located in Quality Management section 8000.30 Review of Practitioner Office Medical Records *Located in Fraud, Abuse, Waste Prevention section		Page 52 Page 6
8.4	**Service Authorization**				
8.4.1	Service authorization includes, but is not limited to, prior authorization, concurrent authorization and post authorization.	Met Addressed in Prior Authorization LA (p. 9).	AMA 7100.05 Prior Authorization LA	Services Requiring Authorization	Page 9
8.4.2	The MCO UM Program policies and procedures shall include service authorization policies and procedures consistent with 42	Met Addressed in Prior Authorization LA (p. 9).	AMA 7100.05 Prior Authorization LA	Services Requiring Authorization	Page 9-10

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	CFR §438.210 and state laws and regulations for initial and continuing authorization of services that include, but are not limited to, the following:				
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;	Met Prior Authorization LA (p. 10) contains exact contract language; however, the procedure for service authorization of a member request when a provider refuses service/does not make a timely request is not found. Addressed in the updated policy Prior Authorization LA (p. 10).	AMA 7100.05 Prior Authorization LA	Services Requiring Authorization	Page 10
8.4.2.2	Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;	Met Prior Authorization LA (p. 10) contains only contract language. Actual mechanisms to ensure consistent application addressed in Utilization Management Plan (Processes/Inter-rater Reliability p. 44). Consultation with requesting provider addressed in Prior Authorization LA (p. 16).	AMA 7100.05 Prior Authorization LA	Services Requiring Authorization	Page 10
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;	Met Prior Authorization LA (p. 10) contains only contract language; (p. 13-14) provides detail regarding medical director reviewer responsibilities.	AMA 7100.05 Prior Authorization LA	Services Requiring Authorization	Page 10
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;	Met Prior Authorization LA (p. 10) contains exact contract language; however no mechanism in which a member may submit a service authorization request was found	AMA 7100.05 Prior Authorization LA	Services Requiring Authorization	Page 10

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		in either the policy or member handbook (found under Member Education). The member handbook states a provider may give the plan information regarding a service they think a member needs (p 30). In terms of member requests for services, the reviewer found only that the member could request a continuation of services while an appeal or State Fair Hearing was under review (p. 51). Addressed in the updated policy Prior Authorization LA (p. 10).			
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	Met Prior Authorization LA (p. 10) contains an extensive section of quoted contract language including this requirement. Throughout the remainder of the document, the provision of authorization numbers to in-network and out-of-network providers is noted, without reference to effective dates (p. 2, 12, 25). In separate sections of the document, (i.e., Prior Authorization Period of Validation p. 24, 29) 60 day validity is noted, but not provision of that information or specific dates to the provider.	AMA 7100.05 Prior Authorization LA	Services Requiring Authorization	Page 12

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		Similar information is found in the Utilization Management Plan (Processes/ Prior Authorization Period of Validation p.14). Addressed in the updated policy Prior Authorization LA (p. 12).			
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.	Met Prior Authorization LA (p. 10) contains an extensive section of quoted contract language including this requirement, although a description of electronic system specifications, or procedures incorporating the use of these systems, are not found (in either this policy or the Utilization Management Plan). Addressed in the updated policy Prior Authorization LA (p. 10).	AMA 7100.05 Prior Authorization LA	Services Requiring Authorization	Page 10
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.	Met Prior Authorization LA (p. 10) contains exact contract language, albeit without supporting procedures for concurrent review in either this policy or Utilization Management Plan/Processes.	AMA 7100.05 Prior Authorization LA	Services Requiring Authorization	Page 10
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. Standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.	Met Prior Authorization LA (p. 10) contains exact contract language. For approvals, also incorporated into the decisions/notification table (p. 19). For denials, see notice of action requirements below.	AMA 7100.05 Prior Authorization LA	Services Requiring Authorization	Page 10

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8.5.1.2	The MCO shall make ninety-five percent (95%) of 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.	Met Prior Authorization LA (p. 10) contains exact contract language. For approvals, also incorporated into the decisions/notification table (p. 19). For denials, see notice of action requirements below.	AMA 7100.05 Prior Authorization LA	Services Requiring Authorization	Page 10
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.	Met Addressed in Prior Authorization LA p. 10 (exact contract language), p. 18 (decision/notification requirements table), p. 20-21 (narrative).	AMA 7100.05 Prior Authorization LA	Services Requiring Authorization	Page10- 11
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 DHH a need for additional information and how the extension is in the member's best interest.	Met Addressed in Prior Authorization LA p. 10-11 (exact contract language), p. 23 (expedited extensions for pre-service review) and p. 23-24 (expedited extensions for concurrent review).	AMA 7100.05 Prior Authorization LA	Services Requiring Authorization	Page 11
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.	Met Addressed in Prior Authorization LA p. 21 (decision/notification requirements).	AMA 7100.05 Prior Authorization LA	Decision/Notification Requirements	Page 21
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 material omission or	Met Addressed in Prior Authorization LA p. 21.	AMA 7100.05 Prior Authorization LA	Decision/Notification Requirements	Page 21

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	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.	Met Prior Authorization LA (p. 21) contains exact contract language. For denials, also incorporated into the decisions/notification table (p. 19).	AMA 7100.05 Prior Authorization LA	Decision/Notification Requirements	Page 21
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 healthcare 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.	Met Prior Authorization LA (p. 21) contains exact contract language. For denials, also incorporated into the decisions/notification table (p. 19).	AMA 7100.05 Prior Authorization LA	Decision/Notification Requirements	Page 21
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(a) and (c) and 42 CFR §438.210(b)(c)(d) and Section § 12 of this RFP for member written materials.	Met Prior Authorization LA (p. 21-22) contains exact contract language. The plan could submit a template notice of action.	AMA 7100.05 Prior Authorization LA	Decision/Notification Requirements	Page 21-22
8.5.4.1.2.2	The MCO shall notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration,	Met Prior Authorization LA (p. 21) contains exact contract language.	AMA 7100.05 Prior Authorization LA	Decision/Notification Requirements	Page 22

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	or scope that is less than requested. The MCO shall notify the provider rendering the service, whether a healthcare 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 notification to the provider within two (2) business days of making the initial certification.	As noted, also incorporated into the decisions/notification table (p. 19).			
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 a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.	Met Addressed in Prior Authorization LA (p. 24) and Utilization Management Plan (Processes/Informal Reconsideration p. 34).	AMA 7100.05 Prior Authorization LA	Informal Reconsideration Process	Page 24
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).	Met Addressed in Prior Authorization LA (p. 24) and Utilization Management Plan (Processes/Informal Reconsideration p. 34).	AMA 7100.05 Prior Authorization LA	Informal Reconsideration Process	Page 24
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 determination cannot be available within one (1) working day.	Met Addressed in Prior Authorization LA (p. 24) and Utilization Management Plan (Processes/Informal Reconsideration p. 34).	AMA 7100.05 Prior Authorization LA	Informal Reconsideration Process	Page 24
8.5.4.1.3.4	The Informal Reconsideration will in no way extend the 30 day required timeframe for a Notice of Appeal Resolution.	Met Addressed in Prior Authorization LA (p. 24) and Utilization Management Plan (Processes/Informal Reconsideration p. 34).	AMA 7100.05 Prior Authorization LA	Informal Reconsideration Process	Page 24

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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.	Met Addressed in Prior Authorization LA (p. 11).	AMA 7100.05 Prior Authorization LA	Exceptions to Service Authorizations	Page 11
8.5.4.2	The MCO shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.	Met Addressed in Prior Authorization LA (p. 11).	AMA 7100.05 Prior Authorization LA	Exceptions to Service Authorizations	Page 11
8.5.4.2	The MCO shall not require service authorization or referral for EPSDT screening services.	Met Addressed in Prior Authorization LA (p. 11).	AMA 7100.05 Prior Authorization LA	Exceptions to Service Authorizations	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.	Met Addressed in Prior Authorization LA (p. 11).	AMA 7100.05 Prior Authorization LA	Exceptions to Service Authorizations	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 members linkage to the plan.	Met Addressed in Prior Authorization LA (p. 11).	AMA 7100.05 Prior Authorization LA	Exceptions to Service Authorizations	Page 11
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 healthcare services and prenatal care.	Met Addressed in Elective Referrals LA (p. 3).	AMA 7100.10 Elective Referrals LA *Located in Core Benefits and Services section	Initiating Referrals	Page 3
8.5.4.2	The MCO shall not require a PCP referral for in-network eye care and vision services.	Met Addressed in Elective Referrals LA (Core Benefits and Services p. 3).	AMA 7100.10 Elective Referrals LA *Located in Core Benefits and Services section	Initiating Referrals	Page 3
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.	Met Prior Authorization LA (p. 12) contains exact contract language. Aetna Better Health of Louisiana may require notification. It is not	AMA 7100.05 Prior Authorization LA	Exceptions to Service Authorizations	Page 12

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		clear whether the plan will require notification of pregnancy, or selectively require notification in unspecified circumstances. Addressed in the updated policy Prior Authorization LA (p. 12).			
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.	Met Prior Authorization LA (p. 12) contains exact contract language. Aetna Better Health of Louisiana may require notification. It is not clear whether the plan will require notification of delivery. Addressed in the updated policy Prior Authorization LA (p. 12).	AMA 7100.05 Prior Authorization LA	Exceptions to Service Authorizations	Page 12
8.5.4.2	The MCO may require notification by the provider of inpatient emergency admissions within one (1) business day of admission.	Met Prior Authorization LA (p. 12) contains exact contract language. Aetna Better Health of Louisiana may require notification. It is not clear whether the plan will require notification of emergency admissions. Addressed in the updated policy Prior Authorization LA (p. 12).	AMA 7100.05 Prior Authorization LA	Exceptions to Service Authorizations	Page 12
8.6	**Service Authorization Pharmacy Services**				
8.6.1	Prior authorization may be used for drug products under the following conditions: • When prescribing medically necessary non-Formulary or non-preferred (non-PDL) drugs. • When prescribing drugs inconsistent with FDA approved labeling, including behavioral health drugs. When prescribing is inconsistent	Met Addressed throughout Pharmacy Prior Authorization policy.	7100.07 Pharmacy Prior Authorization	Pharmacy Authorization Guidelines	Page 6

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	with nationally accepted guidelines. • When prescribing brand name medications which have A-rated generic equivalents. • To minimize potential drug over-utilization. • To accommodate exceptions to Medicaid drug utilization review standards related to proper maintenance drug therapy.				
8.6.2	DHH may prohibit prior authorization for selected drug products or devices at its discretion.				
8.6.3	Any prior approval issued by the MCO shall take into consideration prescription refills related to the original pharmacy service. The MCO must notify the requesting practitioner of the approval or disapproval of the request within 24 hours once relevant medically necessary information is obtained from the prescriber.	Met Addressed as follows in Pharmacy Prior Authorization (p. 7-8): Aetna Better Health of Louisiana makes pharmacy authorization decisions and notifies prescribing providers, and/or members in a timely manner, according to the standards defined below unless other decision/notification time standards are required by the department: • Aetna Better Health of Louisiana makes decisions within 24 calendar hours of receiving all necessary information. • Aetna Better Health of Louisiana notifies requesting prescribing providers by fax, phone or electronic communication of the approved decisions within 24 calendar hours.	7100.07 Pharmacy Prior Authorization	Decision and Notification Standards	Page 6 - 8

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		• If an authorization is denied, Aetna Better Health of Louisiana gives requesting prescribing providers and members' electronic or written confirmation of the decisions within two business days after determination. Perhaps the plan verbally notifies providers of denials within 24 hours as well, but this is not clear in the policy. Addressed in the updated policy Pharmacy Prior Authorization (p. 8).			
8.6.4	The MCO must provide access to a toll-free call center for prescribers to call to request prior authorization for non-preferred drugs or drugs that are subject to clinical edits. The MCO must allow prescribers and pharmacies to submit prior authorization requests by phone, fax or automated process. If the MCO or its pharmacy benefit manager operates a separate call center for prior authorization requests, it will be subject to the provider call center standards set forth in Section 10.	Met Addressed in Pharmacy Prior Authorization (p.4-5), although only phone and fax are specified.	7100.07 Pharmacy Prior Authorization	Provider Requirements	Page 4 and 5
8.6.5	The MCO shall not penalize the prescriber or enrollee, financially or otherwise, for such requests and approvals.	Met Addressed in Pharmacy Prior Authorization (p.5).	7100.07 Pharmacy Prior Authorization	Provider Requirements	Page 5
8.6.6	Details of prior authorization requests or offering of an alternative medication shall be provided to the prescriber and/or member in writing.	Met Addressed in Pharmacy Prior Authorization (p.6).	7100.07 Pharmacy Prior Authorization	Pharmacy Prior Authorization Unit Requirements	Page 6
8.6.7	An enrollee receiving a prescription drug that was on the MCO's Formulary or PDL, and subsequently removed or changed, shall be permitted to continue to receive that prescription drug if determined to be medically	Met Addressed in Formulary (p. 7).	7600.10 Formulary *Located in Core Benefits and Services section	Formulary Revision	Page 7

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	necessary for at least sixty (60) days. The MCO must make that determination in consultation with the prescriber.				
8.6.8	If a prescription for a medication is not filled when the prescription is presented to the pharmacy due to a prior authorization requirement, the MCO must have an automated process that allows the pharmacy to dispense up to a 72-hour supply of a product or full unbreakable packages without having to obtain an override. The pharmacy may fill consecutive 72-hour supplies if the prescriber remains unavailable but the MCO is only required to pay one dispensing fee. The MCO must reimburse the pharmacy for dispensing the temporary supply of medication.	Met Addressed in Pharmacy Prior Authorization (p.8).	7100.07 Pharmacy Prior Authorization	Decision and Notification Standards	Page 8
8.6.9	A member, or a provider on Member's behalf, may appeal prior authorization denials in accordance with Section 13 (Grievances and Appeals).	Met Addressed in Member Appeals LA (p. 4).	3100.70 Member Appeals LA *Located in Member Grievance and Appeals Procedures section		Page 4
8.7	**Step Therapy and/or Fail First Protocols**				
8.7.0	The MCO is allowed to implement step therapy or fail first protocols to first drive utilization toward the most cost-effective and safest drug therapy. These protocols may be applied to either individual drugs or classes of drugs. However, the MCO must provide a clear process for a provider to request an override of such restrictions. An override shall be granted when the prescribing physician can demonstrate, based on sound clinical evidence, that the preferred treatment required under the step therapy or fail first protocol: • Has been ineffective in the treatment of the Medicaid enrollee's disease or medical condition; • Will be expected to be ineffective based on the known relevant physical or mental characteristics and medical history of the Medicaid	Met Addressed in Pharmacy Prior Authorization (p.3).	7100.07 Pharmacy Prior Authorization	Definitions	Page 3

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	enrollee and known characteristics of the drug regimen; or • Will cause or will likely cause an adverse reaction or other physical harm to the Medicaid enrollee.				
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 DHH, for purposes of making medical necessity determinations.	Met Addressed in Prior Authorization LA (p. 12).	AMA 7100.05 Prior Authorization LA	Responsibility	Page 12
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.	Met Addressed by Prior Authorization LA (p. 15) and LA Provider Manual (p. 42).	AMA 7100.05 Prior Authorization LA LA Provider Manual *Located in Provider Services section	Practitioner and Provider Requirements	Page 15 Page 42
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.	Met Addressed by Prior Authorization LA (p. 15) and LA Provider Manual (p. 42).	AMA 7100.05 Prior Authorization LA LA Provider Manual *Located in Provider Services section	Practitioner and Provider Requirements	Page 15 Page 42
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 DHH, the MCO shall, at a minimum, impose financial penalties against the provider as appropriate.	Met Addressed by Prior Authorization LA (p. 15) and LA Provider Manual (p. 42).	AMA 7100.05 Prior Authorization LA LA Provider Manual *Located in Provider Services section	Practitioner and Provider Requirements	Page 15 Page 42