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 details of the Plan's Grievance and Appeals Policy. The requirement is also addressed in the Member Handbook pages 57-61.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Policy Statement & Overview	Page 1 - 2
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:** On page 6, the policy states that "The MCOs 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"	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Special Requirement Appeals	Page 5 - 6
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:** The requirement is addressed on page 1 in the policy overview section of the policy. The requirement is also addressed in the Member Handbook pages 57-61.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Overview	Page 1
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 1, the policy states that "All levels of the MCO's internal appeal & grievance process must be exhausted prior to moving to a State Fair Hearing".	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Overview	Page 1
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	**Met** Future compliance for this element will be based on review of files and reporting. The plan submitted sample letters relating to Notice of Disposition, Notice of Denial of Preservice Authorization and Notice of Termination or Reduction. An attachment to a Notice of Denial letter included language regarding the State Fair Healing process. The letters address the member's right to continuation of benefits. The member handbook addresses the member's potential financial liability if the State Fair Hearing upholds the MCOs decision, as does the attachment "Your Appeal Rights" It is strongly recommended that the plan ensure that members be informed of potential financial liability whenever notification of an adverse decision is provided to the member.	This is a requirement and shouldn't be in policy		

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
	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.	Onsite IPRO discussed the plans process for logging complaints, grievances, and appeals. All calls are handled by the national call center. The call center resolves some issues. Issues that are not resolved are routed to the plan for review. The plan does not have a clear mechanism for ensuring that all issues resolved by the call center – for example potential grievances – were appropriately resolved. The plan should receive reports from the call center for all calls other than inquiries that were not routed to the plan for resolution. The plan should monitor these cases and conduct audits of the cases as needed.			
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:** The policy addresses the details of the Plan's Grievance and Appeals Policy. The requirement is also addressed in the Member Handbook pages 57-61.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Overview	Page 1 & 2
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:** – On page 1, the policy states appeals and grievances may be "submitted on behalf of members, such as by providers authorized as member representatives." It also states that "with member's written consent a network provider may file an appeal or grievance or request for a State Hearing on behalf of a member." and "All levels of the MCO's internal appeal & grievance process must be exhausted prior to moving to a State Fair Hearing". Member Handbook page 58 states "You or someone acting on your behalf (provider, family member, etc.) can file an appeal by calling or writing" the Plan and "If someone else is going to file a grievance for you, we must have your written permission for that person to file your appeal."	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Overview	Page 1
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:** On page 1, the policy states appeals and grievances may be "submitted on behalf of members, such as by providers authorized as member representatives." It also states that "with member's written consent a network provider may file an appeal or grievance or request for a State Hearing on behalf of a member."	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Overview	Page 1

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
		Member Handbook page 58 states "You or someone acting on your behalf (provider, family member, etc.) can file an appeal by calling or writing" the Plan and "If someone else is going to file a grievance for you, we must have your written permission for that person to file your appeal."			
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:** The requirement is addressed in the policy on page 6 which states that for a standard appeal, the maximum timeframe is 30 days unless the resolution timeframe is extended. For expedited appeals, the maximum timeframe is 3 working days, but UHG policy is to default to NCQA standard which is 72 hours. For grievances, the maximum timeframe is 90 calendar days of receipt for a grievance regarding access to services. Member Handbook page 57 states that "You have 30 days to file your grievance from the date of the event that caused you to be unhappy."	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft) Member Handbook	Case Completion Timeframes Grievance and Appeals	Page 6 Page 55
13.2.4 13.2.4.1	**Procedures for Filing -** The member may file a grievance either orally or in writing.	**Met:** The requirement is met on page 1 of the policy which states that "The member may file a grievance either orally or in writing." The Member Handbook page 57 also addresses the requirement detailing how the member can file a grievance or appeal orally by calling Member Services or in writing via a letter to the Plan (contact information provided).	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Overview	Page 1
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:** Page 7 of the policy addresses the requirement that members are informed of the State Fair Hearings process and how to request a state hearing. The requirement is also addressed in the Member Handbook pages 57-61 which provides details of the Plan's Grievance and Appeal process. Page 58 addresses the procedure for filing a request for a State Fair Hearing. Page 61 contains a copy of the "Request for State Fair Hearing Form". The form notes that the member can submit a request for a state hearing by mail, fax or online via http://www.adminlaw.state.la.us/HH.htm. The grievance policy and the Member Handbook indicate that the member can file a grievance or appeal orally or in writing via a letter and the Member Handbook provides the specific contact information for submission. The plan submitted a template for a grievance form as follow up. However, members are not required to use any specific form and can file grievances orally.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Content of Resolution Letters	Page 6 - 7
13.3	**Grievance/Appeal Records and Report**				

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
13.3.1	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, 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.	**Met:** On page 8, the policy states that the Plan "must maintain records for all appeals and grievances including the resolution for a period of six years. The plan submitted an updated version of the policy which addresses litigation language on page 8 of the final document.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Document Retention	Page 7 - 8
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:** On page 8, the policy states that the Plan "is required to submit information regarding appeal and grievance activity as directed by DHH". The plan submitted an updated version of the policy which addresses monthly reporting and required data elements on page 8 of the final document.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Document Retention A.	Page 8
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 1, the definition of the Grievance Coordinator position states that this employee is "responsible for communicating directly with the member to gather information as well as compilation and submission of the Summary of Evidence to the Division of Administrative Law. The Summary of Evidence is an important document in the State Fair Hearing process." The policy discusses the internal step-by-step details of the processing of a member appeal/grievance. The plan provides quarterly reports on Denials to DHH. A sample of letters is submitted on a weekly basis.	LA Fair Hearing SOP	Overview	Page 1
13.4	**Handling of Grievances and Appeal**				
13.4.1	**General Requirements –** In handling grievances and appeals, the				

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
	MCO must meet the following requirements:				
13.4.1.1	Acknowledge receipt of each grievance and appeal in writing;	**Met:** On page 3, the policy states "Acknowledgement letters will be sent upon receipt of the appeal to comply with applicable acknowledgement letter requirements." On page 4, the policy states that the Plan "will send written acknowledgment of the receipt of an appeal within 3 working days of receipt if appeal is submitted in writing. Oral acknowledgement is acceptable if the appeal is submitted orally." The Member Handbook page 58 states "If you file your appeal by calling us, we will put your appeal in writing and send it to you for your signature. You must sign and return the appeal." "We will send you a letter telling you we received your appeal."	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Process Requirements Acknowledgement Letters	Page 3 Page 4
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:** On page 7, the policy addresses the requirement as follows: A description of the next level of appeal within the organization or to an external organization, if applicable, along with timeframes and instructions for filing. For appeal decisions not resolved wholly in the member's favor, the written notice to the member must also include information regarding:(a) Oral interpretation is available for any language; (b) Written translation is available in prevalent languages as applicable; (c) Written alternative formats may be available as needed; (d) How to access the MCP's interpretation and translation services as well as alternative formats that can be provided by the MCP; (e) The right to request a state hearing; (f) How to request a state hearing; and if applicable:(i)The right to continue to receive benefits pending a state hearing; (ii) How to request the continuation of benefits. The Member Handbook on page 51 discusses Interpreter Services and Language Assistance available to members. This is also addressed in the Grievance and Appeals section of the Member Handbook pages 57-61.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft) Member Handbook	Content of Resolution Letters Interpreter Services and Language Assistance	Page 7 Page 49
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 condition or disease: an appeal	**Met:** On page 4 Review Requirements, the policy states "The Revolving Analyst assigned to the case is an individual not involved in the previous decision and is not a subordinate of the individual who made the previous decision." and "makes the decision for non-clinical appeals based upon the plan documents and in accordance with applicable regulatory requirements." The policy also states "For appeals involving clinical issues"…"a health care professional with appropriate clinical expertise in treating the member's condition or disease and who is not a subordinate of the individual who made the previous decision must review the appeal."	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Process Requirements	Page 3

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	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.				
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:** The requirement is met on page 1 of the policy which states that "The member may file a grievance either orally or in writing." On page 5, the policy states for expedited appeals that Plan "not require than an oral filing be followed by a written, signed appeal." The Member Handbook page 57 also addresses the requirement detailing how the member can file a grievance or appeal orally by calling Member Services or in writing via a letter to the Plan (contact information provided). On page 58, it states that "If you file your appeal by calling us, we will put your appeal in writing and send it to you for your signature. You must sign and return the appeal."	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	3. Expedited Appeals	Page 5
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 5, the policy states that the Plan "Inform the consumer of the limited time available for the consumer to present evidence and allegations of fact or law in person or in writing."	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	3. Expedited Appeals / D.	Page 5
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 3, the policy states "The member or member's representative may examine the case file, including medical records and any other documents and records, before and during the appeal process."	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Process Requirements / 4.	Page 3
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:** The plan submitted a revised Policy which addresses legal representation of a deceased member's estate.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Overview	Page 1
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	**Met:** LA Training – RA V2 (A&G Resolving Analyst Training Plan) spreadsheet notes that training titled "Types: Appeals, Grievances and State Fair Hearing" is planned for 2.00 hours on 1/21/2015.	Training: LA Training –RA V2 FWA 120314 V4	Training Plan Tab on Excel sheet Fraud Waste Abuse	

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	member and providers.	FWA 120314 V4 – notes new hire online/self study titled C&E@Work Lesson – Fraud Waste and Abuse New Hire Training. The latest completion due date noted on the report is 12/18/14. Status of training will be discussed during the onsite review.		Learn Source course completion status	
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 2, the policy details the responsibilities of the Medical Director/Chief Medical Officer. On page 8, the policy details the responsibilities of the Grievance System Manager who "manages and adjudicates member and provider disputes arising under the grievance system including member grievances, appeals and requests for hearing and provider claim and disputes. The grievance systems manager is qualified by training and experience to process and resolve complaints, grievances and appeals and is responsible for the grievance system."	Dr. Ann K Logarbo –Medical Director/Chief Medical Officer	4.2 Key Staff Job Descriptions	Page 2
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 5, the policy states "If a determination is not made on accordance with the timeframes specified in 13.7 of the RFP, the member's request will be deemed to have been approved as of the date upon which a final approved as of the date upon which a final determination should have been made".	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Special Requirements	Page 5 - 6
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:** On page 7, Content of Resolution Letters, the policy states "For appeal decisions not resolved wholly in the member's favor, the written notice to the member must also include information regarding"…"the right to request a state hearing" and "how to request a state hearing". The Member Handbook, pages 59-61, details the process for the member to seek a State Fair Hearing. On page 59, the handbook states that the member "may file a State Hearing request within 30 days from the date shown on our decision letter."	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Overview	Page 1
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	**Met:** The requirement is addressed on page 7 in the section titled Content of Resolution Letters.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)		Page 6

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	§ 12 of this RFP to ensure ease of understanding.				
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 addressed on page 7 in the section titled Content of Resolution Letters.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Content of Resolution Letters	Page 6 - 7
13.5.2.2	The reasons for the action;	**Met:** The requirement is addressed on page 7 in the section titled Content of Resolution Letters.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Content of Resolution Letters	Page 6 - 7
13.5.2.3	The member's or the provider's right to file an appeal with the MCO;	**Met:** The requirement is addressed on page 7 in the section titled Content of Resolution Letters.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Content of Resolution Letters	Page 6 - 7
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 addressed on page 7 in the section titled Content of Resolution Letters.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Content of Resolution Letters	Page 6 - 7
13.5.2.5	The procedures for exercising the rights specified in this section;	**Met:** The requirement is addressed on page 7 in the section titled Content of Resolution Letters.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Content of Resolution Letters	Page 6 - 7
13.5.2.6	The circumstances under which expedited resolution is available and how to request it; and	**Met:** The requirement is addressed on page 7 in the section titled Content of Resolution Letters.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Content of Resolution Letters	Page 6 - 7
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 addressed on pages 6-7 in the section titled Content of Resolution Letters. In the Member Handbook under State Fair Hearing and in an attachment to a Denial Notice titled "Your Appeal Rights", the member's potential financial liability is addressed if the State Fair Hearing upholds the MCO' decision. The plan submitted 3 additional sample letters, all of which addressed continuation of benefits. IPRO makes the following recommendations regarding the Member Handbook. The plan should clarify the member's right to an appeal, prior to the State Fair Hearing process and the right to continuation of benefits during the Appeal process. Page 59 of the Member Handbook describes the process for continuing benefits within the context of State Fair Hearing, but not within the context of the Appeals process. IPRO further recommends that the plan ensure that members be informed	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Content of Resolution Letters	Page 6 - 7

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		of potential financial liability whenever notification of an adverse decision is provided to the member.			
13.5.2.8	Oral interpretation is available for all languages and how to access it.	**Met:** The requirement is addressed on page 7 in the section titled Content of Resolution Letters.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Content of Resolution Letters	Page 6 - 7
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 State Fair Heating Companion Guide on page 6 defines the Notice Of Adverse Action as "any written notice informing the member of any HP or DHH or its agent action which unfavorably affects his/her Medicaid benefit". The plan provided a template letter which provides the member with 15 days notice of the action.	State Fair Hearing Companion Guide Notice of Action Sample (Denial Letter)	Definitions Continuation of Benefits	Page 6 Page 3
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 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	**Not Met:** The State Fair Heating Companion Guide on page 6 defines the Notice Of Adverse Action as "any written notice informing the member of any HP or DHH or its agent action which unfavorably affects his/her Medicaid benefit". The document does not contain any references to a 5 day time frame requirement related to member fraud and/or the subsections listed in the requirement. In follow up documents the plan referred to the State Fair Hearing Companion Guide as a State authored document that is not subject to their edits. The issue regarding reduction of notice is not related to State Fair Hearing and should be included in the plan's policy.	State Fair Hearing Companion Guide Notice of Action Sample (Denial Letter)	Definitions Continuation of Benefits	Page 6 Page 3

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	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.	**Not Met:** Reference to the requirement for denial of payment could not be found in the Plan's documentation. In follow up documents the plan referred to the State Fair Hearing Companion Guide as a State authored document that is not subject to their edits. The issue regarding denial of payment is not related to State Fair Hearing and should be included in the plan's policy.	State Fair Hearing Companion Guide Notice of Action Sample (Denial Letter)	Definitions Continuation of Benefits	Page 6 Page 3
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:** On page 6, the policy states that the member may submit a request to "extend the timeframe to resolve a standard or expedited appeal up to fourteen days". It also notes that the Plan may request an extension up to 14 days if it can demonstrate that the extension is in the best interest of the member. Member Handbook page 58 notes the same requirements as noted above.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Case Completion Timeframes	Page 6
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 as expeditiously as the member's health condition	**Met:** On page 6, the policy states "If DHH approves the extension, UnitedHealthcare must immediately give the member written notice of the reason for the extension and the date that a decision was made."	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Case Completion Timeframes	Page 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)
	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 plan provided an updated policy which includes reference to 13.6.3.3 timeframes under definition of action.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Case Completion Timeframes	Page 6
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:** On page 6, the policy states that the maximum timeframe for expedited appeals is 72 hours. Member Handbook page 59 advises the member to contact the Plan "If you or your doctor wants a fast decision because your health is at risk." It also states the Plan "will call you with our decision within 72 hours of getting your request for an expedited review".	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Case Completion Timeframes	Page 6
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:** On page 6, the policy states that the member may submit a request to "extend the timeframe to resolve a standard or expedited appeal up to fourteen days". It also notes that the Plan may request an extension up to 14 days if it can demonstrate that the extension is in the best interest of the member. Member Handbook page 58 notes the same requirements as noted above.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Case Completion Timeframes	Page 6
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:** The requirement is addressed on page 4, section Review Requirements.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Review Requirements /3. E.	Page 6
13.6.1	**Specific Timeframes**				
13.6.1.1	**Standard Disposition of Grievances -**	**Met:** Completion Timeframes page 67 states "Grievances – the maximum	UnitedHealthcare Community Plan	Case Completion	Page 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)
	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.	timeframe is as follows: within 90 days of receipt for a grievance regarding access to services.	Louisiana Grievance System Process (Draft)	Timeframes / Grievances	
13.6.1.2	**Standard Resolution of Appeals -** For standard resolution of an appeal and notice to the affected parties, the timeframe is established as thirty (30) calendar days from the day the MCO receives the appeal. This timeframe may be extended under § 13.7.2 of this section.	**Met:** Completion of Timeframes page 6 states "Standard appeals – the maximum timeframe is 30 calendar days, unless the resolution timeframe is extended."	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Case Completion Timeframes / Standard Appeals	Page 6
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:** Completion Timeframe page 6 states "Expedited appeals – the maximum timeframe is 3 working days, but UHC policy is to default to NCQA standard which is 72 hours."	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Case Completion Timeframes / Standard Appeals	Page 6
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 6, the policy states that the member may submit a request to "extend the timeframe to resolve a standard or expedited appeal up to fourteen days". It also notes that the Plan may request an extension up to 14 days if it can demonstrate that the extension is in the best interest of the member. Member Handbook page 58 notes the same requirements as noted above.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Case Completion Timeframes / Standard Appeals	Page 6
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 6, the policy states "If DHH approves the extension, UnitedHealthcare must immediately give the member written notice of the reason for the extension and the date that a decision was made."	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Case Completion Timeframes / Standard Appeals	Page 6
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	**Met:** The requirement is addressed in the Review Requirements section C which states that for expedited appeals the Plan will "Make reasonable efforts to provide prompt oral notification to the consumer of the decision	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Review Requirements / 3. C.	Page 5

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
	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.	to expedite or not expedite the appeal resolution."			
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:** The requirement is addressed in the policy on page 7 in section Content of Resolution Letters.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Content of Resolution Letter	Page 6
13.6.5	**Requirements for State Fair Hearings -** The MCO shall comply with all requirements as outlined in this RFP.	**Met:** On page 1, the policy states "With the member's written consent a network provider may file an appeal or grievance or request a State Fair Hearing on behalf of a member." On page 7, Content of Resolution Letters, the policy states "For appeal decisions not resolved wholly in the member's favor, the written notice to the member must also include information regarding"…"the right to request a state hearing" and "how to request a state hearing". The Member Handbook, pages 59-61, details the process for the member to seek a State Fair Hearing. On page 59, the handbook states that the member "may file a State Hearing request within 30 days from the date shown on our decision letter."	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Overview	Page 1
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 7, Content of Resolution Letters, the policy states "For appeal decisions not resolved wholly in the member's favor, the written notice to the member must also include information regarding"…"the right to request a state hearing" and "how to request a state hearing".	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Case Completion Timeframes / Standard Appeals	Page 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)
		The Member Handbook, pages 59-61 details, the process for the member to seek a State Fair Hearing. On page 59, the handbook states that the member "may file a State Hearing request within 30 days from the date shown on our decision letter."			
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 1, the policy states that purpose of the policy is to "process appeals and grievances submitted by members and by authorized representatives, including providers submitting on behalf of members." Member Handbook page 58 states "You or someone acting on your behalf (provider, family member, etc.) can file an appeal by calling or writing" the Plan and "If someone else is going to file a grievance for you, we must have your written permission for that person to file your appeal." The plan submitted an updated policy which includes language regarding representative of deceased member's estate on p 1. Auditors recommend that this language be included in the member handbook.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Overview	Page 1
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:** The requirement is addressed in the policy on page 5 Review Requirements section 3.A-H.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Review Requirements / 3. A – H	Page 5 - 6
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, who requests an expedited resolution or supports a member's appeal.	**Met:** The requirement is addressed in the policy on page 5 Review Requirements section 3.G.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Review Requirements / 3. G.	Page 6
13.7.2	**Action Following Denial of a Request for Expedited Resolution –**	**Met:** The requirement is addressed in the policy on page 5 Review Requirements section 4.A-B.	UnitedHealthcare Community Plan Louisiana Grievance System Process	Review Requirements / 4. A	Page 6 & 7

Contract | RFP Reference	Contract Requirement Language	Reviewer Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
	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.		(Draft)	& B	
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 5, the policy states "If a determination is not made on accordance with the timeframes specified in 13.7 of the RFP, the member's request will be deemed to have been approved as of the date upon which a final approved as of the date upon which a final determination should have been made".	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Case Completion Timeframes	Page 7
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 and allegations of fact or	**Met:** The requirement is addressed in the policy on page 5 Review Requirements section 3.A-H.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Review Requirements / 3. Expedited Appeals A - H	Page 5 - 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)
	law, in person and 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:** On page 1, the policy states appeals and grievances may be "submitted on behalf of members, such as by providers authorized as member representatives." It also states that "with member's written consent a network provider may file an appeal or grievance or request for a State Hearing on behalf of a member." Member Handbook page 58 states "You or someone acting on your behalf (provider, family member, etc.) can file an appeal by calling or writing" the Plan and "If someone else is going to file a grievance for you, we must have your written permission for that person to file your appeal."	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Overview	Page 1
13.7.6	**Format of Resolution Notice –** In addition to written notice, the MCO must also make reasonable effort to provide oral notice.	**Met:** The requirement is addressed in the policy on page 5 Review Requirements section 3.F.	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Review Requirements / 3. F.	Page 6
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	**Met:** The requirement is addressed in the CSA_Louisiana_Medicaid_Grievance_System_Process_Policy_12_03_14 on page 4 Process Requirements section 5. The requirement is also addressed in the State Fair Heating Companion Guide page 10. Auditors recommend that the plan should clarify the language in the Member Handbook to include continuation of benefits during the appeals process. The current language references continuation of benefits during the Fair Hearing process only.	State Fair Hearing Companion Guide Notice of Action Sample (Denial Letter)	Health Plan Responsibility Continuation of Benefits	Page 10 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)
	not expired; and • the member requests extension of benefits.				
13.8.3	**Duration of Continued or Reinstated Benefits –** If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs: • the member withdraws the appeal; • ten (10) days pass after the MCO mails the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10) day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached; • a State Fair Hearing Officer issues a hearing decision adverse to the member; • the time period or service limits of a previously authorized service has been met.	**Met:** The requirement is addressed in the CSA_Louisiana_Medicaid_Grievance_System_Process_Policy_12_03_14 policy on page 4 Process Requirements section 5. The requirement is also addressed in the State Fair Heating Companion Guide page 10.	State Fair Hearing Companion Guide Notice of Action Sample (Denial Letter)	Health Plan Responsibility Continuation of Benefits	Page 10 Page 3
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:** The requirement is addressed in the CSA_Louisiana_Medicaid_Grievance_System_Process_Policy_12_03_14 policy on page 9 Content of Resolution Letters section (f).ii which states "If the MCP action is upheld at the state hearing that the member may be liable for the cost of any continued benefits." The requirement is also addressed in the State Fair Hearing Companion Guide page 10 which states "If the final resolution of the Prepaid HP's internal appeal and/or the State Fair Hearing is adverse to the member, that is, upholds the Prepaid HP's action, the Prepaid HP may recover the cost of the services furnished to the member during the pendency of the internal	State Fair Hearing Companion Guide Notice of Action Sample (Denial Letter)	Health Plan Responsibility Continuation of Benefits	Page 10 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)
		appeal and/or the State Fair Hearing, to the extent that they were furnished solely because of the requirements for continued benefits." The requirement is also addressed on page 59 of the Member Handbook which states "If the State Fair Hearing judge finds the decision we made in your case is correct, that is, rules against your appeal, you may be required to repay the amount of any benefits you received during the State Fair Hearing process."			
13.9	**Information to Providers and Contractors**				
13.9.0	The MCO must provide the information specified at 42 C.F.R. § 438.10(g)(1) about the grievance system to all providers and contractors at the time they enter into a contract.	**Met:** The requirement is addressed on pages 17-18 in the Provider Handbook which addresses Grievances, Complaints and Member Appeals.	Provider Handbook	Grievances and Complaints	Page 17
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:** On page 6, the policy states "The MCO grievance and appeals procedures and 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." On page 8, the policy states that the Plan "is required to submit information regarding appeal and grievance activity as directed by DHH."	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Special Requirement Appeals	Page 5 - 6
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:** The plan submitted an updated policy which addresses the requirement on p 6 under Special Requirements	UnitedHealthcare Community Plan Louisiana Grievance System Process (Draft)	Process Requirements	Page 3 - 4
13.11.2	**Services Furnished While the Appeal is Pending –**	**Met:** The plan submitted an updated policy which addresses the requirement on p 6 under Special Requirements	UnitedHealthcare Community Plan Louisiana Grievance System Process	Process Requirements	Page 3 - 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)
	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.		(Draft)		