Amerigroup RealSolutions in healthcare	**DEPARTMENT PROCEDURE**

Subject: **Member Grievance and Grievance Appeal - MLTC- NY**		
Primary Department: Managed Long Term Care – Health Plan	**Secondary Department(s):** Quality Management – Health Plan	**Prior Procedure Reference(s):**
Effective Date of Procedure: December 1, 2005	**Date Procedure Last Reviewed:** December 28, 2011	**Date Procedure Last Revised:** December 28, 2011
Plan CEO Approval/Signature:	**Corporate Dept Sr Mgmt Approval/Signature:**	**Check Only One:** ☐ Procedure is Corporate Owned ☑ Procedure is Health Plan Owned

Check All That Apply:
Procedure is applicable to:

☐ Corporate

☐ All Health Plans

Only the following Health Plans (please list): New York (MLTC)
(Note: If there are multiple Health Plans within a state, please list each specific Health Plan directly above, as appropriate)

Purpose

This Amerigroup Community Care process has the following objectives:

1) Ensure that the member is informed of his or her rights to file a grievance and to appeal grievance decisions;
2) Ensure that members' grievances are resolved promptly;
3) Ensure that all actions and resolutions are communicated to the member on a timely basis;
4) Ensure that grievance activity is reported accurately to government oversight agencies;
5) Ensure that grievance information is used to assess and improve Amerigroup's performance.

The Grievance System regulation in Subpart F of 42 CFR Part 438 applies to both "expressions of dissatisfaction" by enrollees (grievances) and to requests for a review of an "action" (as defined in 438.400) by a managed long-term care plan (an appeal). For the purposes of this policy, the process will describe grievances and a separate policy (Appeals of Adverse Determinations – MLTC - NY) will address Action Appeals.

Definitions

Grievance - An expression of dissatisfaction by the member or provider on the member's behalf about care and/or treatment that does not amount to a change in scope, amount or duration of service. A grievance can be verbal or in writing. Amerigroup does not require that members put grievances in writing.

Expedited grievance - Amerigroup determines or the provider indicates that a delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. A member may

also request an expedited review of a grievance.

Grievance Appeal - A request for a review of a grievance decision.

Inquiry - A written or verbal question or request for information posed to Amerigroup regarding benefits, contracts or organizational rules. Inquiries are not reported on Quarterly Report Summaries to the State Department of Health (SDOH).

National Customer Care (NCC) department - Refers to the Amerigroup call center which consists of well-trained Customer Care Representatives (CCR) that receives calls from members who require assistance.

Dedicated Service Unit (DSU) – Refers to the call center located in Florida which consists of Personal Service Specialist (PSS) front line call service associates dedicated to Managed Long Term Care (MLTC) members.

Facets - Refers to a data management system for clinical information, authorizations, provider/member information and claims payment used by Amerigroup.

Procedures

Grievance Process

1) The enrollee, or his or her designee, may file a grievance regarding any dispute with Amerigroup orally or in writing.
2) Amerigroup will make professional interpreter services, assistance with completing forms and TTY/TDD telephone services available at any stage in the grievance process upon request of the enrollee, or his or her designee.
3) The Care Manager or Member Advocate will contact the member in an attempt to resolve the grievance immediately (same day) whenever possible.
    a) If the grievance is able to be resolved on the same day, the resolution is documented in computer tracking system and the case is referred to the Member Complaint Specialist in the Quality Management department for quality improvement purposes. A written response is not required.
    b) If the grievance is <u>not</u> resolved on the same day, the resolution is documented in Facets and the case is referred to the Member Complaint Specialist in the Quality Management department who will generate the acknowledgement letter, including the resolution, no more than fifteen (15) business days after the grievance was filed.
4) Anyone who receives a grievance from a member or from a provider's office on behalf of a member should refer the member to Amerigroup's Dedicated Service Unit (DSU) or MLTC Care Manager or member advocate.

5) The Personal Service Specialist (PSS) is trained to assist members in resolving service problems, common inquires, the importance of member rights and responsibilities and other concerns. The PSS will provide assistance to members who wish to file a grievance. If the grievance is regarding a denial letter, the CRR will give the member appeal rights and follow the appeal process. The PSS will log this as a member grievance.
6) The PSS will respond to inquiries and resolve service problems immediately whenever possible. If the member is not satisfied and/or wants to file a formal grievance, the PSS will collect the necessary information to file the grievance.
7) The PSS will record the oral or mailed grievances in a log and route it to Corporate Quality Management department.
8) In the case of receipt of a written grievance, Document Management Control scans the written grievance into the member's folder in the Amerigroup electronic documentation system and forwards the written grievance to the designated Corporate Member Complaint Specialist mailbox.
9) The Corporate Member Complaint Specialist codes the grievance in Facets based on New York specific coding requirements.
10) The Corporate Complaint Specialist will forward the grievance to the designated New York Complaint Specialist within twenty-four (24) hours using the Amerigroup Facets system.
11) The Corporate Complaint Specialist will generate an acknowledgement letter within fifteen (15) business days of receipt of the grievance about the grievance procedure, timeframes for processing and resolving grievances, and the member's right to complain to SDOH or the Local Department of Social Services (LDSS).
12) The Member Complaint Specialist will receive the grievance via Facets and contact the member to verify the content of the grievance and collect any additional information needed to make a determination. Two (2) phone call attempts and two (2) outreach letters are mailed in an effort to resolve the grievance.
13) All grievances are reviewed by one (1) or more qualified personnel.
14) If a grievance is urgent in nature and/or needs resolution by persons able to make a high level policy decisions, an ad hoc Grievance Committee will be established and may consist one or more of the following: the Chief Executive Officer, the Medical Director, the General Counsel, and a member of the Board of Managers.
15) The Member Complaint Specialist will refer all grievances regarding clinical matters to the Quality Management Coordinator for further review and investigation by a certified or registered health care professional. (See Quality of Care Internal Referral Process – NY, Quality of Care Complaint Process - NY and Peer Review Process - NY procedures).
16) Grievances received through SDOH, the LDSS, the Department of

Health and Human Services (HHS) or any other government body are referred to the Member Compliant Specialist for resolution, tracking, reporting and quality improvement activities.

17) Amerigroup analyzes and takes action on grievances and satisfaction data and tracks and trends grievance for member dissatisfaction, network access, quality of care and health plan improvement opportunities.
18) Member grievance related to dissatisfaction with a provider and/or services received are tracked, trended and reported as on-going monitoring recredentailing cycles.
19) If the grievance involves the member's Care Manager, it will be referred to the Director of Managed Long Term Care for investigation and resolution and routed to the Quality Management (QM) Member Complaint Specialist. If the grievance is of an urgent nature (serious quality of care issue, alleged abuse, fraud, etc.) and/or requires the intervention of persons able to make high level policy decisions, it is immediately referred to the Vice President (VP) of MLTC. The VP of MLTC may solicit the participation of the Chief Medical Officer or other appropriate staff in resolving the grievance.

Standard/Expedited

1) New York State MLTC Contract, Appendix K requires member grievances to be resolved no more than forty-eight (48) hours after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health, but no longer than seven (7) calendar days from the receipt of the grievance.
2) All other grievances will be resolved within forty-five (45) calendar days after the receipt of all necessary information and no more than sixty (60) days from the receipt of the grievance. Amerigroup will maintain reports of grievances unresolved after forty-five (45) calendar days (in accordance with Section 18 of the agreement).
3) If a member grievance requires input from other departments, the member grievance will not be closed until all the necessary information has been obtained to resolve the grievance investigation and Amerigroup has made a determination as to the validity of the grievance.
4) An extension may be requested by the member or the provider on the member's behalf (written or verbal) for up to fourteen (14) calendar days. Amerigroup may also initiate an extension if the Amerigroup Care Manager can justify the need for additional information and if extension is in member's interest. Requests for extension, whether member, provider or plan initiated, must be well documented describing rationale for the extension. All extensions are documented in Facets.
5) For health plan initiated extensions, the QM Member Complaint

Specialist will send the member a letter indicating the justification for the extension, explaining how the delay is in the best interest of the member and identifying any additional information that the plan requires, from any source to make its determination.

Grievance Determination

1) Grievance determination shall be made in writing to the enrollee or his/her designee. The determination shall include detailed reasons for the determination, clinical rationale for the determination, if applicable, procedures for filing an appeal of the determination and DSU (1-800-950-7679) phone number and notice of his/her right to contact the SDOH. The toll-free number for SDOH is 1-866-712-7197 for grievances.
2) In the case where insufficient information was presented and Amerigroup was unable to make a determination, the enrollee or designee will receive a written statement that the determination could not be made due to insufficient information was not obtained to make a determination.
3) In cases where a delay would significantly increase the risk to enrollee's health, Amerigroup will provide notice of the determination by telephone directly to the enrollee or designee. When phone is not available, some other method of communication will be used, with written notice to follow within three (3) business days.
4) If the grievance is referred for a potential quality issue investigation, the member will be informed via a Member Quality of Care Resolution Letter of the determination and reasons for that decision. Amerigroup keeps track of all grievances we received about quality of care and we will continue to monitor the provider/facility and take action when needed.
5) The outcome of the investigation becomes part of the peer review and recredentailing process (See Quality Of Care Complaint Process – NY and Peer Review Process – NY procedures).

Reporting and Record Keeping

1) Quarterly Summary Reports of grievances and grievance appeals are submitted to the SDOH within fifteen (15) business days of the close of the quarter (in accordance with Section 18 of the agreement).
2) Grievances unresolved within forty-five (45) days are reported to the SDOH.
3) On a quarterly basis, grievances are presented to the Quality Management Committee for review.
4) Records will be kept on each grievance and grievance appeals with the following information:
    a) Date grievance was filed

b) Copy of the grievance if written
c) Date receipt of and copy of the enrollee's written confirmation if any
d) Log of grievance determination with date of determination and titles of the personnel and credentials of clinical personal who reviewed the grievance
e) Date and copy of the enrollee's grievance appeal
f) Enrollee or provider requests for expedited grievance appeal and Amerigroup's determination
g) Determination and date of determination of the grievance appeals
h) Titles and credentials of clinical staff who reviewed the grievance appeals

Grievance Appeals Process

1) The enrollee or designee has no less than sixty (60) business days after receipt of the notice of grievance determination to file a written grievance appeal.
2) Within fifteen (15) business days of a receipt of a grievance appeal, Amerigroup will provide an acknowledgement of the grievance appeal, including the name, address, and telephone number of the individual designated to respond to the appeal. Amerigroup will indicate what information, if any, must be provided to render a determination.
3) Grievance appeals of clinical matters will be decided by personnel qualified to review the appeal, including licensed, certified or registered health care professionals who did not make the initial determination, at least one (1) of whom must be a clinical peer reviewer as defined by the agreement.
4) Grievance appeals of non-clinical matters will be determined by qualified personnel at a higher level than that of the personnel who made the original grievance determination.
5) Grievance appeals will be decided and notification provided to the enrollee no more than:
   a) Two (2) business days after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health; or
   b) Thirty (30) business days after the receipt of all necessary information in all other instances.
6) The grievance appeal determination notice will include detailed reasons for the determination, clinical rationale for the determination if applicable, notice of the enrollee's option to contact the SDOH at 1-866-712-7197.

Exceptions None

References New York Medicaid Contract; Section 14 & 18

	Appendix F - “New York State Department of Health and Grievance System Requirements for Medicaid Managed Care and Family Health Plus Programs”; Appendix E- “New York State Department of Health Member Handbook Guidelines; New York MLTC contract; Appendix K PHL 4408-a 10NYCRR 98-1.14(e) Subpart F CFR Part 438 NCQA Accreditation Standards and Guidelines: Policies for Complaints and Appeals
Related Policies and Procedures	Quality of Care Complaint Process - NY Quality of Care Internal Referral Process - NY Peer Review Process - NY Fair Hearings Rights - NY Appeals of Adverse Determinations Member Rights and Guidelines – NY External Appeals Rights – NY Appeals of Adverse Determination – MLTC - NY
Related Materials	MLTC Acknowledgment Standard Grievance Letter MLTC Acknowledgment Expedited Grievance Letter MLTC Notice of Extension Standard Grievance Letter MLTC Notice of Extension Expedited Grievance Letter MLTC Grievance Resolution Letter MLTC Grievance Resolution of Expedited Grievance Letter MLTC Acknowledgement of Grievance Appeal Letter MLTC Acknowledgement of Standard Grievance Appeal and Request for Additional Information Letter MLTC Grievance Appeal Decision Letter Provider Educational Letter Balance Billing Letter Non-Par Provider Billing Issue Letter