AMERIGROUP	NY Medicaid Advantage & NY Medicaid Advantage Plus PROCEDURE	
Subject: NY Medicaid Advantage and Medicaid Advantage Plus Complaints/Grievances		
Primary Department: Medicare Complaints Appeals and Grievances (MCAG)	**Secondary Department(s):** NY Health Plan – Quality Management Designated Service Unit (DSU)	**Prior Procedure Reference(s):** Member Grievances
Effective Date of Procedure: January 1, 2010	**Date Procedure Last Reviewed:**	**Date Procedure Last Revised:**
CEO Approval/Signature: (Signature/Date)	**Dept Sr. Mgmt Approval/Signature:** (Signature/Date)	**SSO Compliance Approval/Signature:** (Signature/Date)
Procedure is applicable to (check all that apply): ☐ All Medicare Plans ☐ Specialty Plans ☐ Balance Plans ☐ Classic Plans ☐ Choice Plans Only the following Markets (please list each by City and State): NY Medicaid Advantage & Medicaid Advantage Plus		**Check Only One:** ☑ Procedure is Corporate Owned ☐ Procedure is Health Plan Owned

Purpose

This document explains the regulated timeframes associated with Medicare Advantage and New York Medicaid Advantage (& New York Medicaid Advantage Plus) complaints and grievances associated with benefits covered under both programs. The timeframe for review and resolution of complaints and grievances is regulated by the Centers for Medicare and Medicare Services (CMS) and the State of New York. Please note that for those complaints specific to the Medicare line of business, the issue will default to the Medicare Advantage Grievance Procedure. Those complaints specific to the Medicaid Advantage line of business will default to the Medicaid Complaint/Grievance and Complaint/Grievance Appeal process. The procedure outlined in this process is applicable to benefits covered under both programs.

Definitions

Complaint/Grievance Medicare – Any expression of dissatisfaction to a Medicare Health Plan, provider, facility, or Quality Improvement Organization (QIO) either orally or in writing. Under New York State Public Health Law, the Complaint Medicaid-Complaint/Grievance System regulation in Subpart F of 42 CFR Part 438 (NYC Appendix F: Complaints Appeals, Grievances and Non-Utilization Review Action Appeals) applies to a member's expressions of dissatisfaction with any aspect of care other than an Action. A complaint means the same as a grievance under New York State Public Health Law.

Complaint/Grievance Appeal - is a request for a review of a complaint determination and is available only under the Medicaid process.

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Inquiry - is 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).

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Expedited Complaint/Grievance – A dispute with the Plans decision not to expedite an appeal as requested. In filing an expedited grievance, it is believed that a delay in processing the expedited appeal will adversely affect the member's health or his/her ability to function.

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Procedure

It is the policy of the Plan that Medicare Advantage, New York Medicaid Advantage and New York Medicaid Advantage Plus member complaints are appropriately acknowledged, processed and tracked in compliance within the guidelines and timeframes established by the Centers for Medicare and Medicaid Services (CMS) and New York State Department of Health (SDOH) contract.

For those complaints specific to the Medicare line of business, the issue will default to the Medicare Advantage Grievance Procedure. Those complaints specific to the Medicaid Advantage (Medicaid Advantage Plus) lines of business will default to the Medicaid Complaint/Complaint Appeal process. The procedure outlined in this process is applicable to benefits covered under both programs.

Timeframes for Processing Complaints & Grievances

The timeframe for processing a complaint/grievance is different under the Medicare and Medicaid Advantage (Medicaid Advantage Plus) requirements depending upon whether the covered service is a Medicare only service, Medicaid Advantage (Medicaid Advantage Plus) only service, or a service that could fall under either Medicare or Medicaid Advantage (Medicaid Advantage Plus) program. The Health Plan and Medicare Complaints Appeals and Grievances (MCAG) will log and process the Member complaints that are applicable to benefits covered under both programs in both the Medicaid and Medicare databases and follow the most stringent of both processes to benefit the Member. The MCAG and Health Plan Quality Management (QM) Departments will work together to provide the utmost service to the Member.

The Complaints/Grievance timeframe begins when AMERIGROUP receives the complaint/grievance. AMERIGROUP's complaint process for MAP shall indicate the following specific timeframes regarding complaint resolution:

If AMERIGROUP immediately resolves an oral Complaint to the Enrollee's satisfaction, that Complaint may be considered resolved without any additional written notification to the Enrollee. Such Complaints must be logged by the Plan and reported on a quarterly basis

~~. Add to this paragraph from Appendix F3 7(a) i without the reference to Section 18.~~

Type	Timeframe
MA/MAP Medicare Complaint/Grievance Expedited	• Resolved and verbally advised of decision within twenty-four (24) hours. • Resolution letter issue within three (3) calendar days of verbal notification.
MA/MAP Medicare Complaint/Grievance Standard	• Resolved ~~w~~ithin thirty (30) calendar days of AMERIGROUP's receipt of issue. ** The Plan may ~~e~~xtend the thirty (30) calendar day timeframe by (14) calendar days if the enrollee requests the extension or if AMERIGROUP justifies a need for additional

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	information and documents how the delay is in the interest of the enrollee. The enrollee must be notified in writing of the reasons for the delay.
MA/MAP Medicaid Complaint/Grievance Expedited	• Resolved and verbally advised of decision within twenty-four (48) hours but no more than 7 days of receipt of information. • Resolution letter issue within three (3) calendar days of verbal notification.
MA/MAP Medicaid Complaint/Grievance Standard	• Resolved within forty five (45) days and no more than sixty (60) days of receipt of information

Complaint/Grievance Process

1) The enrollee, or his or her designee, may file a complaint regarding any dispute with AMERIGROUP orally or in writing.
2) Anyone who receives a complaint from a member or from a provider's office on behalf of a member should refer the person to the AMERIGROUP Dedicated Service Unit (DSU).
3) DSU Member Services Representatives (MSR) are trained to assist members in resolving service problems and other concerns and provide assistance to members who wish to file a complaint.
4) MSRs respond to inquiries and resolve service problems immediately whenever possible. If the issue cannot be resolved same day, if the member is not satisfied with the DSU outcome or wants to file a formal complaint, an MSR collects the necessary information to file the complaint.
5) The MSR forwards the complaint to the Medicare Complaints, Appeals & Grievance Department (MCAG) for processing.
6) The MCAG Department coordinates a review of the issue with the New York Health Plan Quality Management Department documenting the issue in both department databases for proper reporting as applicable.
7) An acknowledgement letter is sent within fifteen (15) calendar days of receipt of the compliant unless resolution is obtained prior. This acknowledgement letter includes information about the complaint procedure, timeframes for processing and resolving complaints, and the member's right to complain to SDOH. ~~or the Local Department of Social Services (LDSS).~~
8) All complaints are reviewed by one or more qualified personnel.
9) If a complaint is expedited or urgent in nature and/or needs resolution by persons able to make high level policy decisions, one or more of the following Plan individuals are contacted: the Chief Executive Officer, the Medical Director, the General Counsel, and a member of the Board of Managers.
10) The Complaint Coordinator refers all complaints regarding clinical matters to the appropriate Health Plan's Quality Management Coordinator and MCAG Clinical Reviewer for further review and investigation.
11) Complaints received through SDOH, the LDSS, the Department of Health and Human Services (HHS) will be tracked through this process.

Complaint/Grievance Determination

1) Complaint determination shall be made in writing to the enrollee or his/her designee. 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 on the date the allowable time to resolve the complaint has expired.
2) In cases where a delay would significantly increase the risk to enrollee's health, AMERIGROUP will provide notice of determination by telephone directly to the enrollee or designee. When a telephone number is not available, a written notice will follow within three (3) business days.
3) The complaint determination notice will include detailed reasons for the determination, and notice of the enrollee's option to contact the SDOH at 1-800-206-8125 for Medicaid Advantage and SDOH at 1-866-712-7197 for Medicaid Advantage Plus

Complaint/Grievance Appeals Process – As this is not a requirement of Medicare, the Complaint Appeal process will follow existing NY Health Plan Policies & Procedures.

1) The enrollee or designee has no less than sixty (60) business days after receipt of the notice of complaint determination to file a written complaint appeal.
2) Within fifteen (15) business days of a receipt of a complaint appeal, AMERIGROUP will provide an acknowledgement of the complaint 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) Complaint 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 of whom must be a clinical peer reviewer as defined by the agreement.
4) Complaint appeals of non-clinical matters will be determined by qualified personnel at a higher level than that of the personnel who made the original complaint determination.
5) Complaint 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 complaint 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 1-800-206-8125 (Medicaid Advantage) or SDOH at 1-866-712-7197 for Medicaid Advantage Plus

Reporting and Record Keeping

1) Quarterly CMS Reporting on Member Grievances are filed with CMS.
2) Quarterly Summary Reports of complaints and complaint 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).

3) Complaints unresolved within forty-five (45) days are reported to the SDOH.
4) On a quarterly basis, complaints are presented to the Quality Management Committee (QMC) for review.
5) Records will be kept on each complaint and complaint appeals with the following information:
   a) Date complaint was filed;
   b) Copy of the complaint if written;
   c) Date of receipt and a copy of the enrollee's written confirmation if any;
   d) Log of complaint determination with date of determination and titles of the personnel and credentials of clinical personal who reviewed the complaint;
   e) Date and copy of the enrollee's complaint appeal
   f) Enrollee or provider requests for expedited complaint appeal and AMERIGROUP's determination;
   g) Determination and date of determination of the complaint appeals;
   h) Titles and credentials of clinical staff who reviewed the complaint appeals.

Exceptions None

References

1) Medicare Managed Care Manual, Section 20.3: New York Medicaid Advantage Contract; Section 14; New York Medicaid Advantage Plus Contract; Section 14
2) Appendix F - "New York State Department of Health and Grievance System Requirements for Medicaid Managed Care and Family Health Plus Programs"; Medicaid Advantage and Medicaid Advantage Plus
3) Appendix E- "New York State Department of Health Member Handbook Guidelines;
4) Public Health Law - PHL 4408-a

Related Policies and Procedures Complaint/Grievance and Complaint/Grievance Appeal Management –NY Classification of Medicare Advantage Healthcare Grievances and their Timeframes

Comment [jf1]: This is the Plan's Medicaid complaint policy

Related Materials N/A