POLICY AND PROCEDURE

POLICY NAME: Grievance Process	**POLICY ID:** LA.QI.11.02
BUSINESS UNIT: LHCC	**FUNCTIONAL AREA:** Quality Improvement
EFFECTIVE DATE: 02/01/15	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE: ~~0~~9/15, 11/15, 9/16, 10/16, 12/16, 7/17, 8/17, 5/18, 8/18, 8/19, 6/20, 3/21, 5/21, 7/21, 7/22, 12/22, ~~0~~9/23, 11/23, 7/24, 9/24	
REGULATOR MOST RECENT APPROVAL DATE(S): n/a	

POLICY STATEMENT:
This policy outlines grievance process.

PURPOSE:
To ensure members and providers have a clear process for reporting complaints and grievances requests and that the Plan has an effective and consistent process for acknowledging, investigating, resolving, and making notification of grievances in a timely manner. The plan has written policies and procedures for thorough, appropriate, and timely resolution of member grievances. The plan has a thorough and consistent process for addressing member grievances.

The plan has policies and procedures for registering and responding to oral and written complaints that include:
- Documentation of the substance of complaints and actions taken.
- Investigation of the substance of the complaints, including any aspect of clinical care involved.
- Notification to members of the disposition of complaints and the right to appeal, as appropriate.
- Standards for timeliness including standards for clinically urgent situations.
- Provision of language services for the compliant process.

SCOPE:
Louisiana Healthcare Connections (LHCC or Plan) Quality Improvement, PHCO, Member Service Departments, and Behavioral Health Management. The scope of services includes both medical and behavioral health services.

DEFINITIONS:
Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the Medicaid program.
Adverse Action – Any decision by the Plan to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested. 42 CFR §438.210(c)
Adverse Determination - An admission, availability of care, continued stay or other health care service that has been reviewed by the Plan and based upon the information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced, suspended, delayed, or terminated.
Appeal – A request for a review of an action pursuant to 42 CFR §438.400(b).
Appeal Procedure - A formal process whereby a member has the right to contest an adverse determination/action rendered by the Plan, which results in the denial, reduction, suspension, termination, or delay of health care benefits/services. The appeal procedure shall be governed by federal and Louisiana Medicaid rules and regulations and any and all applicable court orders and consent decrees.
Benefits or Covered Services - Those health care services to which an eligible Medicaid recipient is entitled under Louisiana Medicaid State Plan.
Business Day -Traditional workdays, including Monday, Tuesday, Wednesday, Thursday, and Friday. State holidays are excluded, and traditional work hours are 8:00 a.m. – 5:00 p.m. Calendar Days - All seven (7) days of the week. Unless otherwise specified, the term "days" in the State Contract refers to calendar days.
External Quality Review Organization (EQRO) — an organization that meets the competence and independence requirements set forth in 42 CFR §438.354 and performs EQR and other related activities f or states with Medicaid managed care programs.
Grievance – An expression of member/provider dissatisfaction about any matter other than an action, as action is defined. Examples of grievances include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee and network administration practices. Administrative grievances are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues.
Grievance Process – The procedure for addressing member's grievances.
Grievance System – A grievance process, an appeal process, and access to the State's fair hearing system. Any grievance system requirements apply to all three components of the grievance system.

Medically Necessary Services - Health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must (1) be deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering; or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary." The LDH-OBH Assistant Secretary and/or The LDH-OBH Assistant Secretary and/or Medical Director, in consultation with the Medicaid Director and/or Medicaid Medical Director, may consider authorizing services at his discretion on a case-by-case basis.
Non-Covered Services - Services not covered under the Title XIX Louisiana State Medicaid Plan.
Second-level grievance: Also known as a non-coverage appeal (NCQA), a second-level grievance means review by the Plan of an unresolved grievance related to non-coverage issues (e.g., Plan denied a member's sixth request in 12 months to change primary care practitioners). Second-level grievances follow the same procedure as outlined in this policy for initial grievances.[LRM1][KFT2]

POLICY:
Plan has established and maintains a procedure for the receipt and prompt internal resolution of all grievances and appeals that complies with 42 CFR, Part 438, Subpart F and all applicable state and federal laws.
The Plan refers all members who are dissatisfied with the Plan or its subcontractor in any respect to the Plan's designee authorized to review and respond to grievances and appeals and requires corrective action.

The grievance procedures ensure that Louisiana Healthcare Connections complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex in accordance with Section 1557 (the nondiscrimination provision) of the Affordable Care Act (ACA). LHCC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

LHCC provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English.
- Qualified interpreters
- Information written in other languages[LRM3]

PROCEDURE:
The Plan will maintain a grievance system that complies with 42 CFR Part 438, Subpart F. The Plan establishes and maintains a procedure for the receipt and prompt internal resolution of all grievances and appeals in accordance with all applicable state and federal laws.

The Plan's grievance and appeals procedures and any changes thereto must be approved in writing by LDH prior to their implementation and must include at a minimum the requirements set forth in the current State Contract. The Plan refers all of the Plan's members who are dissatisfied with the Plan or its subcontractor in any respect to the Plan's designee authorized to review and respond to grievances and appeals and require corrective action.

The member must exhaust the Plan's internal grievance/appeal procedures prior to accessing the State Fair Hearing process.

The Plan does not create barriers to timely due process. The Plan shall be subject to sanctions if it is determined by LDH that the Plan has created barriers to timely due process, and/or, if ten (10) percent or higher of appeal 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 Plan member choice forms;
- Labeling grievances as inquiries and funneled into an informal review;
- Failing to inform members of their due process rights;
- Failing to log and process grievances and appeals;
- Failure to inform members of the right to continuation of benefits; and
- Failure to issue a proper notice including vague or illegible notices;

- Failure to inform members of their right to State Fair Hearing following the PLAN's internal appeals process.

When the term "member" is used throughout this policy, it includes the member, member's authorized representative, or provider with the member's prior written consent.

General Grievance System Requirements

Grievance System

The Plan established and maintains a system for receiving, reviewing, and resolving member Grievances and Appeals. Components shall include a Grievance process, an Appeal Procedure, and a process to access a State Fair Hearing.

If the resolution of the grievance affects the member's ability to receive benefit coverage, access to care, access to services or payment for care or services and wasn't resolved to the member's satisfaction, the member will be notified of their additional internal appeal rights through the issuance of an Adverse Benefit Determination letter. ~~and/or their external appeal rights through the issuance of a State Hearing Form as appropriate.~~

The Plan shall permit a member to file a grievance and request an MCO level appeal subject only to the limitations expressly provided in this Policy. ~~A member shall be permitted to request a State Fair Hearing after receiving notice that the action is upheld or once the PLAN's appeals process has been exhausted.~~ ~~[LRM4]~~~~[LRM5]~~[KFT6]

Filing Requirements

Authority to File:

A member, or authorized representative acting on the member's behalf, may file a grievance and a Plan level appeal, and may request a State Fair Hearing once the Plan's appeals process has been exhausted.

A network provider, acting on behalf of the member and with the member's prior written consent, may file an appeal. A network provider may file a grievance or request a State Fair Hearing on behalf of a member.

Time Limits for Filing

The member shall be permitted to file a grievance at any time.

The member must be allowed sixty (60) calendar days from the date on the Plan's notice of action or inaction to request an appeal.

Procedures for Filing

The member, member's authorized representative 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. These oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal).

The member may file an appeal either orally or in writing.

The Plan shall ensure that all Plan members are informed of the State Fair Hearing process and of the Plan's grievance and appeal procedures. The Plan provides to each member a member handbook that includes descriptions of the Plan's grievance and appeal procedures. Forms with which members may file Grievances or Appeals are available through the Plan and shall be provided upon request of the members. The Plan makes all forms readily accessible on the Plan's website.

Grievance/Appeal Records and Reports

The Plan and its subcontractors shall maintain a complete and accurate record of all Grievances and Appeals for a period of no less than ten (10) years following termination of the State Model Contract. The Plan shall make Grievance and Appeal records available upon request by LDH and CMS. The record of each Grievance and Appeal contains, at a minimum, the information specified in 42 C.F.R. §438.416(b).

The Plan logs, tracks, and trends all Grievances, regardless of the degree of seriousness or whether the Member expressly requests filing the concern. The Plan reports on Grievances and Appeals to LDH in a manner and format determined by LDH to include, but not be limited to: member's name and Medicaid number, summary of grievances and appeals; date of filing; current status; date of review or review meeting; resolution information for each level of grievance or appeal, if applicable; date of resolution at each level, if applicable; and resulting corrective action.

The Plan shall track and investigate any complaints received from enrollees that the billed services were not rendered as stated. The Plan will be responsible for promptly forwarding any adverse decisions to LDH for further review/action upon

request by LDH or the Plan's member. LDH may submit recommendations to the Plan regarding the merits or suggested resolution of any grievance/appeal.

Handling of Grievances and Appeals

General Requirements

In handling grievances and appeals, the Plan must meet the following requirements:

Requests from the LDH Member Complaints Unit and requests for assistance with locating specialists shall be addressed within seventy-two (72) hours unless there is a clinical indication that it is needed sooner. For expedited decisions where a provider indicates, or the Plan 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 Plan must make an expedited 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 complaint. [KFT7]

The Plan shall refer all Members who are dissatisfied with the Plan or its activities to the Plan's Grievance system.

Acknowledge receipt of each grievance and appeal in writing; within five (5) business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the monthly grievance log.

The Plan shall assist the Enrollee in completing forms and following the procedures for filing a Grievance or Appeal or requesting a State Fair Hearing. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability and the plan provides language services through bilingual staff or interpreter services to help members through the complaint process. Use of contracted services is not considered delegation.[LRM8]

Oral interpretation of documents that are written in English into a member's preferred language. Member notification documents are available in languages other than English. Language-line interpretation services are available for registering oral complaints.

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, nor a subordinate of any such individual.

The Plan ensures that all decisions on Grievances and Appeals are made by health care professionals in accordance with federal regulations in treating the member's condition or disease:

- An appeal of a denial that is based on lack of medical necessity.
- A grievance regarding denial of expedited resolution of an appeal.
- A grievance or appeal that involves clinical issues.

Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial action.

As part of the updated Section 1557 requirements, Centene is required to keep track of all discrimination-related grievances across the organization, regardless of the intake channel. This is in addition to any existing reporting that the Grievance Team may currently be doing.

The Grievance Team will utilize the process below to report:

- Any 1557-related issue that has been resolved so that it can be tracked appropriately in the 1557 Repository.
- Close the loop with the 1557 Triage Coordinator Team whenever any 1557 issues are received through the dedicated 1557 contact channels and sent over to the grievance team following the appropriate Member Services process. (Notes will indicate that the issue was received by the 1557 Service Coordinator.)

Grievance Team – Notification Process

The Grievance Team will notify the 1557 Service Coordinator by email @ SM_Section1557Coord@centene.com within 3 business days from when the 1557 issue is resolved.

Training of Plan Staff

The Plan's staff are educated concerning the importance of the grievance and appeal procedures and the rights of the member and providers.

Identification of Appropriate Party
The appropriate individual or body within the Plan having decision-making authority as part of the grievance/appeal procedure shall be identified.

Failure to Make a Timely Decision
Appeals shall be resolved no later than stated time frames and all parties shall be informed of the Plan's decision. If a determination is not made in accordance with the timeframes specified in the State Contract, the member's request will be deemed to have been exhausted the Plan's appeal process as of the date upon which a final determination should have been made. The member may then initiate a State Fair Hearing.

Right to State Fair Hearing
The Plan shall inform the member of their right to seek a State Fair Hearing if the member is not satisfied with the Plan's decision in response to an appeal and the process for doing so.

Notice of Action
Language and Format Requirements
The notice must be in writing and must meet the language and format requirements of 42 CFR §438.10 and the current State contract).

Content of Notice of Action
The Notice of Action must explain the following:

- The action the Plan or its contractor has taken or intends to take;
- The reasons for the action, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
- The member's right to file an appeal with the Plan;
- The member's right to request a State Fair Hearing, after the PLAN's one level appeal process has been exhausted.
- The procedures for exercising the rights specified in this Section;
- The circumstances under which expedited appeal is available and how to request it;
- 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; and
- **Availability of interpretation services for all languages and how access them.**

Timing of Notice of Action
The Plan must mail the Notice of Action within the following timeframes:

For termination, suspension, or reduction of previously authorized Medicaid- covered services, at least ten (10) days before the date of action:

In cases of verified member fraud, or when LDH has facts indicating that action should be taken because of probable member fraud, at least five (5) days before the date of action;

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
- if the member submits 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 level of medical care; or as otherwise permitted under 42 CFR §431.213. for denial of payment, at the time of any action affecting the claim.

Untimely service authorizations constitute a denial and are thus adverse actions.

For expedited service authorization decisions where a provider indicates, or the Plan 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 Plan 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.

The Plan 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 Plan justifies (to LDH upon request) a need for additional information and how the extension is in the member's interest.

LDH will conduct random reviews to ensure that members are receiving such notices in a timely manner.

Resolution and Notification
The Plan shall dispose of a Grievance and resolve each Appeal, and provide notice, as expeditiously as the Member's health condition requires, within the timeframes established herein.

Specific Timeframes[LRM9]
The Plan shall respond to requests for information from LDH within the following timelines:

- Requests from LDH shall be acknowledged in writing within one (1) Business Day and addressed within five (5) Business Days, or within the time-period specified by LDH in the request;
- Requests that originate from the Office of the Governor, the LDH Office of the Secretary, or a Louisiana legislator shall be addressed within seventy-two (72) hours;
- Requests from the LDH Provider Relations Unit shall be addressed within five (5) Business Days; and
- Requests from the LDH Enrollee Complaints Unit and requests for assistance with locating specialists shall be addressed within seventy-two (72) hours unless there is a clinical indication that it is needed sooner.

If the Plan does not provide the requested information within the timeframes outlined in the State Contract or in the LDH request, LDH may assess Monetary Penalties as outlined in the State Contract and *Attachment G, Table of Monetary Penalties*.

Standard Disposition of Grievances
The Plan shall review the Grievance and provide written notice to the Member of the disposition of a Grievance no later than ninety (90) Calendar Days from the date the Plan receives the Grievance.

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 Plan receives the appeal. This timeframe may be extended under Section 2.15.3.3 of this Section.

Extension of Timeframes (2.15.3.5)
For standard service authorization decisions that deny or limit services or the disposition of a member grievance, as expeditiously as the member's health condition requires and within fourteen (14) calendar days following receipt of the request for service or member grievance, 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 prior written consent, requests extension; or
- The Plan justifies (to LDH upon request) a need for additional information and how the extension is in the member's interest.

If the Plan extends the timeframe above, it must:

- Provide oral notice of the extension to the Enrollee by close of business on the day the Plan decides to extend the timeframe;
- Within two (2) Calendar days, 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 requires and no later than the date the extension expires.

In the case of that the Plan fails to adhere to the notice and timing requirements in this section, the member is deemed to have exhausted the Plan's appeal process and may initiate a state fair hearing.

Format of Notice of Disposition
All notices shall meet the standards described at 42 CFR §438.10.

Grievances
The Plan will provide written notice to the member of the disposition of a grievance. In the case of an adverse decision of a first and second level grievance, the written notification will include a statement of the member's right to request an additional review of the resolution within 60 days of the contested grievance resolution letter.[KT10]

Information to Providers and Contractors
The Plan must provide the information specified at 42 CFR. §438.10(g)(2)(xi) about the grievance system to all providers and contractors at the time they enter into a contract

Recordkeeping and Reporting Requirements
Reports of grievances and resolutions shall be submitted to LDH as specified in Section 2.15.1.7 of the Model Contract. The Plan shall not modify the grievance procedure without the prior written approval of LDH.

Effectuation of Reversed Appeal Resolutions
Services not Furnished While the Appeal is Pending
If the Plan 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 Plan must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but no later than 72 hours from the date it receives notice reversing the decision.

Services Furnished While the Appeal is Pending
If the Plan 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 Plan must pay for those services, in accordance with the State's Model Contract.

Procedures
1. The Plan shall assist the member in completing forms and following the procedures for filing a Grievance or Appeal or requesting a State Fair Hearing. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
2. Members, their authorized representatives (with written consent from the member), or legal representatives of a deceased member's estate may file an appeal orally or in writing. A network provider may also file a grievance or request a State Fair Hearing on behalf of a member, with the member's prior written consent after the member has exhausted the plan level appeal.
3. A Member, or Authorized Representative acting on the Member's behalf, may file a Grievance or appeal orally or in writing at any time.
4. An oral grievance is generally received by a Customer Service Representative (CSR) through the Plan's toll-free customer service line.
   a. The CSR opens a case in the OMNI documentation system and documents relevant information as provided by the member, including, but not limited to, actions taken, the members previous grievance and appeal history, and any follow-up activities associated with the grievance or appeal. [LRM11]
   b. The CSR may attempt to resolve the grievance at the time of the call or forward to the GAC through the PRIME documentation system.
   c. The grievance is routed to the GAC the same business day.
   d. The Plan's process for handling Member Grievances shall include acknowledgement in writing within five (5) Business Days of receipt of each Grievance.
5. Written correspondence regarding grievances is received in the mailroom, date stamped and forwarded to the GAC the same business day.
   a. Acknowledgement of a written grievance is sent in writing by the GAC within 5 **business** days of the receipt of the grievance at the Plan.
   b. The GAC documents receipt and a description of the grievance and the date of acknowledgement in the tracking system.

Investigation/Research[LRM12]
1. The GAC will research and gather supporting documentation regarding the grievance. This may include contacting the member for additional information, requesting information from the provider office, researching the member's claims history, or reviewing the member's care plan activity.
2. The GAC may send the grievance to another department such as Provider Relations or Customer Services, for further investigation as appropriate.
3. If the GAC receives a grievance that could be a Quality issue, the grievance case is routed to the Quality Improvement department designee for investigation. If the grievance is related to the quality of care the member received or to the

quality of the physician's office visited, the grievance will be brought to the Medical Director for review to determine if an office site visit needs to be performed by either the Provider Relations or the Quality Department. If a trend of 3 or more grievances is identified for any provider within a 90-day period, the information will be reviewed by the Medical Director and a site visit will be made by the Provider Relations or Quality staff according to the type of grievance that was identified. The plan researches and documents issues relevant to the complaint. The plan's policies and procedures for resolving quality-of-care complaints specify when practitioner review is required.

4. As indicated, the GAC may call an internal committee together to review and resolve a grievance.
5. Any grievance related to a quality of care or medical necessity decision will be routed to the Medical Director for review and resolution.
6. The plan shall provide written notice to the member with the grievance resolution and information regarding further appeal rights.

REFERENCES:
Model Contract - section 2.15
Current NCQA standards & guidelines

ATTACHMENTS:

GAC Workflow.vsdx

ROLES & RESPONSIBILITIES:

REGULATORY REPORTING REQUIREMENTS:
La R.S. 46:460.54 applies to material changes to this policy.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Ad Hoc Review	LDH requested a separate Grievance policy and Appeal Policy therefore we will be retiring LA.QI.11 (the combined document) and this policy and LA.QI.11.03 will replace it.	09/24/15
Ad Hoc Review	Wording in this policy was changed to better align with the Behavioral Health RFP effective 12/1/2015 Change MCO to Plan throughout the policy	11/24/15
Ad Hoc Review	Changed DHH to LDH due to state name change Revised Purpose to include Current NCQA standards & guidelines Added Current NCQA standards & guidelines to the policy Revised definitions to be consistent with the current RFP	09/26/16
Annual review	Added current NCQA language to the following sections 13.4.1.2 second paragraph regarding oral interpretation of written documents in member's preferred language 13.6.3.1 second paragraph regarding receipt acknowledgment and resolution notification timelines Added corporate language to 13.6.1.1 second paragraph regarding expedited grievances Removed following sections specific to the appeals process 13.4.2, 13.6.1.2, 13.6.1.3, 13.6.3.2, 13.6.4, 13.7.1-13.7.5	10/24/16
Ad Hoc Review	Added nondiscrimination language of the Affordable Care Act (ACA) in last paragraphs of the policy section	12/19/16
Ad Hoc Review	Added Medicaid and CHIP Managed Care Proposed Rule/ 438.402 effective 7.1.2017 in these sections: 13.2.3, 13.2.4.1	07/24/17
Annual review	Reversed changes made July 2017 as a mandate came from the State of LA stating that the mega rule changes will not go into effect until extension or renewal of contract 2/1/18.	08/24/17
Ad Hoc Review	Review of processes and addition of the changes noted in Amendment 11,MCO RFP Final review 2/2018	05/24/18

Ad Hoc Review	Policy Revision's made per LDH policy review, changed member's written consent to member's prior written consent in the body of grievance policy.	08/24/18
Annual review	No changes	08/26/19
Ad Hoc Review	Under the section labeled "Policy" on page two (2) removed the phrase "such as:" Updated Member grievance process in attachments	06/25/20
Ad Hoc Review	Under "Procedures" 4.d) and 5.b) added the word "business" to change the turnaround time to "business days" Embedded an updated workflow chart Made a couple of grammatical changes	03/25/21
Ad Hoc Review	13.2.4.2: Removed the verbiage requiring members to submit a written, signed appeal after an oral appeal is submitted.	05/2021
Annual review	No changes	07/28/22
Ad Hoc Review	Changes made to language in the following sections to align the policy and procedure with the language in the Model Contract: "Specific Timeframes", "Grievance System", "Procedures for Filing", "General Requirements", "Policy" "Grievance/Appeals Records and Reports"	12/06/22
Annual review	Grammatical Updates Updated Regulatory Reporting Requirements	09/12/23
Ad Hoc Review	Timing of notice of action extension language from Amendment 4 to Model Contract	11/14/23
Annual Review	Modified "second level grievance" to accommodate NCQA standard ~~Midified~~Modified policy to include language assistance ~~providion~~provision Modified Grievance Systems section to include NCQA specific language Modified Grievance and Appeals Handling section to include NCQA standards Modified "grievances" to accommodate appeals for grievance first and second level~~No Revisions~~	~~7~~9/1~~9~~0/2024

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.