AETNA BETTER HEALTH®

d/b/a Aetna Better Health of Louisiana

Policy

Policy Name:	Enrollee Grievance	Page:	1 of 14
Department:	Appeal and Grievance	Policy Number:	3100.90
Subsection:		Effective Date:	02/01/2015
Applies to:	■ Medicaid Health Plans		

PURPOSE:

This policy describes the responsibility of Aetna Better Health for acknowledging and resolving member inquiries, complaints and grievances. It describes how the plan complies with Balanced Budget Act (BBA) rules and state requirements related to members' grievance rights.[1]

STATEMENT OF OBJECTIVE:

The objectives of this policy are to:

- Verify that member inquiries are monitored and addressed so as to validate the possibility of any inquiry actually being a grievance or appeal and to identify inquiry patterns.[2]
- Promote member education regarding grievance rights
- Confirm that member grievances are acknowledged and addressed in a manner that supports an equitable outcome and complies with state and federal requirements
- Facilitate the identification and resolution of issues that impact quality of care and services
- Certify that the grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural grievance by the member
- Facilitate compliance with federal and state laws and rules and state contractual requirements for the member grievance process
- Promote effective management of member grievances
- Provide for accurate maintenance of required documentation
- Provide compliance with reporting requirements

DEFINITIONS:

Adverse Benefit Determination[3]	Adverse Benefit Determination is defined as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service

[1] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.1.1**

[2] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.4.10.1**

[3] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Glossary

	• The denial, in whole or in part, of payment for a service • The failure to provide service in a timely manner, as defined by the State. • The failure of an MCO to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. • The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.
Appeal and Grievance Application	A highly customizable complaint, grievance and appeal application to capture, process, store, and retrieve detailed information on each complaint, grievance or appeal received.
Clinically Urgent Situation	Any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could result in the following circumstances: • Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment • In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
Inquiry	A request from an member for information that would clarify health plan policy, benefits, procedures, or any aspect of health plan function but does not express dissatisfaction.
Member Expedited Grievance	Any written or verbal expression of dissatisfaction by a member, member representative or provider authorized in writing to act on the member's behalf; about denial of expedited processing of a prior authorization or appeal or about the extension of decision making timeframe for a prior authorization or appeal.
Member Grievance	Any written or verbal expression of dissatisfaction by an member, member representative including a provider authorized in writing to act

	on the member's behalf, including complaints about any matter other than an adverse benefit determination. As provided by 42 C.F.R. §438.400, possible subjects for grievances include, but are not limited to, the manner in which Aetna Better Health or delegated entity provides services, timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, item or interpersonal relationships (e.g., rudeness of a provider, cultural barriers or insensitivity, the condition of the doctor's office). Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care (Potential Quality of Care issue).
Member Representative	A person who assists with the complaint/grievance on the member's behalf including, but not limited to, a family member, friend, guardian, primary care practitioner (PCP), women's health care provider (WHCP) or an attorney. The member must designate a representative in writing.
Potential Quality of Care (PQoC) Concerns	A concern raised to the health plan by anyone internal or external that requires investigation as to whether the competence or professional conduct of an individual Aetna Better Health network practitioner, facility, or ancillary provider adversely affects, or could adversely affect, the health or welfare of a member.
Provider[4]	Any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers services.
State Agency	Louisiana Department of Health (LDH)
Timelines	For standard grievances, the organization resolves the grievance within ninety (90) calendar days.[5] For expedited grievances the organization resolved the expedited grievance within seventy-two (72) hours.

[4] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Glossary
[5] 42 C.F.R. § 438.408(b)(1)

LEGAL/CONTRACT REFERENCE:

- 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 13
- **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15**
- State and federal rules and regulations
- Contract / RFP requirements
- 42 C.F.R. § 438.400 – 438.424
- National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans: 2021/2022

FOCUS/DISPOSITION:

Scope

Aetna Better Health's Member grievance system offers a grievance resolution process for resolving member grievances when there is dissatisfaction with any service or care received by the member.[6] Members may file grievances directly with Aetna Better Health either orally or in writing. An member's authorized representative including the member's provider may file a grievance on behalf of the member.

Aetna Better Health will 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 Teletypewriting Device for the Deaf/Teletypewriter (TTY/TTD) and interpreter capability.[7]

Aetna Better Health will verify that the individuals who determine a decision about grievances 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 the state agency, in treating the member's condition or disease:[8]

- A grievance regarding denial of expedited resolution of an appeal
- A grievance that involves clinical issues

[6] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.1.4**
[7] NCQA HP 2021/2022 ME7 A5**; 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.1.5**
[8] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.1.3**

Members or their representatives may submit grievances orally or in writing to any Aetna Better Health staff person. Standard grievances may be filed at any time.[9] Expedited grievances related to the denial of expedited prior authorization or appeal processing; or related to Aetna Better Health taking an extension on the decision making timeframe for a prior authorization, or an appeal must be requested within sixty (60) calendar days of the Expedited Processing letter or the Extension letter.

Aetna Better Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Aetna Better Health will not initiate disenrollment because of the member's attempt to exercise his or her rights under the grievance system.

Aetna Better Health will confirm that no punitive action is taken against a provider who files a grievance or supports an member's grievance.

Notifying Members of Grievance Process[10]

Members are educated regarding the grievance process through:

- Written notification, distributed upon enrollment, explaining the grievance process and containing specific information about:
  - How to contact the Aetna Better Health's member services
  - Identifying the person from the health plan who receives and processes grievances.
  - Indicating that grievance and appeal policies are available at any time upon request
  - Indicating that the notification is available in the member's primary language upon request or in alternative formats based on member need.[11]
  - The right to file a civil rights grievance with direct with the plan or the Civil Rights Coordinator
- Instructions in the Member Handbook:
  - The handbook is included in all new member welcome packets and mailed in time to reach the member within ten (10) days of receiving notification of the member's

[9] 42 C.F.R. § 438.402(c)(i)**; 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.2.1**
[10] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.1.2
[11] NCQA HP 2021/2022 ME7 A5

enrollment. Instructions also provide information regarding what to do in case of denial, reduction, suspension, or termination of services
- Articles in the Aetna Better Health member newsletters
- The Aetna Better Health website

Any changes to the grievance process are submitted to Louisiana Department of Health for approval prior to implementation. Members are then notified at least thirty (30) calendar days in advance of any changes in Aetna Better Health's grievance or appeal policies, when possible.

Aetna Better Health complies with BBA rules and applicable state requirements policies on content, timing, and translation of all member information related to members' grievance rights.[12]

The grievance process is not a substitute for the State fair hearing process. The parties to the State fair hearing include Aetna Better Health, the member, and his or her representative or the representative of a deceased member's estate. Aetna Better Health will comply with decisions reached as a result of the state fair hearing process. Members have the right to request information regarding:
- The right to request a State fair hearing
- The procedures for exercising the rights to appeal or request a State fair hearing
- Representing themselves or using legal counsel, a relative, a friend, or other spokesperson
- The specific regulations that support, or the change in Federal or State law that requires, the action
- The individual's right to request a state fair hearing, or in cases of an action based on change in law, the circumstances under which a hearing will be granted

Notifying Contractors and Providers of Grievance Process

Information regarding the grievance process is distributed to all contractors and to all in-network providers at the time they enter into a contract and to out-of-network providers within ten (10) calendar days of prior approval of a service or the date of receipt of a claim, whichever is earlier.

[12] NCQA HP 2021/2022 ME7 A5

Grievance Committee

The Grievance Committee reviews grievance trends and may resolve issues related to an expression of dissatisfaction filed by members including the grievance request and all supporting documentation. The committee is comprised of two (2) or more staff members, which may include but not limited to:

- Appeal and Grievance manager – chairperson (one (1) voting member as needed)
- Compliance officer (one (1) voting member as needed)
- Appeal and Grievance coordinator
- Officer of the plan who has the authority to require corrective action
- Representatives from Member Services, Provider Relations and Quality Management departments
- If clinical issue – Representative from Medical Management including by not limited to provider with same or similar specialty not involved in any prior decision making on the issue (one voting member as needed)

As needed the voting members of the committee are assigned prior to each meeting. The voting panel will include individuals who were not involved in the grievance issue and who are not a subordinate to any person involved in the original grievance issue.[13] The grievance case is presented to the committee and a resolution is rendered.

Responsibilities

The Appeal and Grievance department assumes primary responsibility for coordinating, managing and resolving member grievances, and for disseminating information to members about their grievance rights. Aetna Better Health executives with the authority to require corrective action are also involved in the grievance process. Regardless of the department in which the information originates, all grievances are documented within Aetna Better Health's Appeal and Grievance Application and submitted on the date of receipt, with supporting documentation, to the Appeal and Grievance manager for review, referral, resolution, and reporting. If the grievance requires research or input by another department, the Appeal and Grievance department will forward the information to the affected department. The Appeal and Grievance department in coordination with any affected department will thoroughly research each grievance using applicable statutory, regulatory, and contractual provisions and Aetna Better Health's written policies and procedures, collecting pertinent facts from all parties

[13] NCQA HP 2021/2022 ME7 A5

including any clinical care involved. The Grievance Committee will consider the additional information and will resolve the grievance.[14]

All data will be tracked, trended and reported to Service Improvement Committee (SIC) and Quality Management Oversight Committee (QMOC) at least quarterly (more frequently if appropriate) summarizing the frequency and resolution of all grievances.

All Aetna Better Health staff persons who engage in member contact must understand the procedures for receiving, documenting, and processing an member grievance and for initiating the appropriate process for resolution.

All written documents from Aetna Better Health relating to a grievance will be written in English and if requested the prevalent non-English language. Oral interpretation services will be available to members at no cost.[15]

Grievance Types

Grievances may include complaints about the manner in which Aetna Better Health or delegated entity provides services, timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievances are primarily categorized as either quality of service or care issues. Sub-categories may be used to assist with a more detailed identification of recurring issues and corresponding improvement opportunities, including but not limited to the following:

- Failure to respect an member's rights
- Service Issues include those such as accessibility or communication
- PQoC concerns
- Interpersonal relationships (e.g. rudeness of a provider, cultural barriers or insensitivity)
- Aetna Better Health Customer Service
- Civil rights complaints of discrimination on the basis of race, color, national origin, age, disability, or sex
- State agency required categories

[14] NCQA HP 2021/2022 ME7 A2
[15] NCQA HP 2021/2022 ME7 A5

Regulatory Complaints

At any time throughout the appeal or grievance process, or instead of the appeal and grievance process, the member may file a complaint with a regulatory body for any reason including dissatisfaction with the outcome of an appeal or grievance.[16] Regulatory complaints may be received from any area of the State though primarily through the Ombudsman's office.

~~Processing of all regulatory complaints will follow the grievance or appeal process timeframes depending on complaint classification unless the regulatory body stipulates a different timeframe for the complaint.~~

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;[17]

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;[18]

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.[19]

If Aetna Better Health does not provide the requested information within the timeframes outlined above or in the LDH request, LDH may assess Monetary Penalties[20]

All regulatory complaints related to dissatisfaction not about coverage will be identified as a regulatory grievance and will be processed and tracked in the Appeal and Grievance Application as a grievance to allow for comprehensive trending of all received complaints regardless of origination.

[16] NCQA HP 2021/2022 ME7 A3
[17] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.2.6.2.1
[18] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.2.6.2.2
[19] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.2.6.2.4
[20] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.2.6.3

Acknowledgement of Grievances[21]

- All verbal member grievances are acknowledged verbally at the time of receipt
- All written member grievances are acknowledged in writing within five (5) business days[22]
- All verbal and written grievances are documented in Aetna Better Health's Appeal and Grievance Application

Investigation and Documentation

Aetna Better Health logs and tracks all inquiries and grievances in the Appeal and Grievance Application.[23] In addition the system maintains for all grievances types:[24]

- The date of receipt of the grievance
- Copy of the grievance, if written
- A copy of the member's acknowledgment letter
- Date of receipt of and a copy of the signed acknowledgment letter, if any
- All requests for expedited processing and the determination if the request meets the requirements for expedited processing
- Necessary documentation to support any extensions and
- The determination made, including the date of the determination, titles, and in the case of a clinical determination, the credentials of the plan's personnel who reviewed the grievance
- The date the member was notified of the determination

Inquiries are probed to determine if the inquiry is actually a grievance or appeal and are tracked to identify patterns of inquiry. The content of the Appeal and Grievance Application will be available to the department in electronic format upon request. Aetna Better Health will retain a copy of the application for ten (10) years.[25]

Upon receipt of an oral or written grievance, Member Services department will document the grievance in the call system and assign to the Appeal and Grievance department. The Appeal

[21] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.2.2**
[22] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 13.4.1.1/ **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.2.2**
[23] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.1.8**
[24] NCQA HP 2021/2022 ME7 A1
[25] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.1.7**

and Grievance department will either conduct the investigation or assign it to the appropriate department to conduct an investigation including any clinical care involved and will document the actions taken.[26] Member Services staff document oral grievances and assign them to the Aetna Better Health specific Appeal and Grievance entity within the call system.

Grievance Resolution and Notification

Aetna Better Health will resolve and respond to written grievances in writing and to oral grievance in writing at the members request within ninety (90) calendar days[27] of the filing date, taking into consideration the urgency of the situation or whether the resolution timeframe has been extended.[28]

All members are advised in writing of the outcome of the investigation of the grievance, inclusive of the right to appeal through State fair hearing when appropriate. These rights are limited to those issues that present an adverse impact to the member, such as denial, reduction or termination of benefits or access to provider care.[29]

Grievances will be resolved within the following time frames and the member will be notified orally the same day as resolution for expedited grievances and in writing within two (2) calendar days of resolution for all grievances.[30] The timeframe for the disposition of a grievance and notice to the affected parties is as follows:[31]

- Within seventy-two (72) hours of receipt for clinically urgent situations or grievances related to when Aetna Better Health extends the timeframe for decision making or when the grievance is the result of the denial of expedited appeal decision making
- Within ninety (90) calendar days of receipt for all other grievances

[26] NCQA HP 2021/2022 ME7 A2
[27] 42 C.F.R. § 438.408(b)(1)
[28] NCQA HP 2021/2022 ME7 A4
[29] NCQA HP 2021/2022 ME7 A3
[30] NCQA HP 2021/2022 ME7 A4
[31] **2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.1.10**

Grievances will be resolved within ninety (90) calendar days[32] and the affected parties notified within two (2) calendar days of resolution. The resolution time period may not be extended.[33] The timeframe for the standard disposition of a grievance and notice to the affected parties is ninety (90) calendar days from the day Aetna Better Health receives the grievance.

OPERATING PROTOCOL:

Systems

- All grievances are entered and tracked in the Appeal and Grievance Application.
- Member, claims, and call information is available from the Aetna Better Health business application system
- Aetna Better Health website

Measurement

Total number of grievances by type, sub-category, related provider if applicable, and resolution code:

- Quality of Care
- Quality of Service
- Total volume of grievance adjudicated within established time frames

Reporting

- Grievance Report(s) to LDH in the format specified by LDH**[34]**
- Grievance Report(s) to Medical Management and Quality Management Oversight Committee
- Management reports monthly and quarterly, more often as directed
- Annual reports as applicable

[32] 42 C.F.R. § 438.408(b)(1)**; 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.2.3**
[33] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 13.6.2**; 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.1.10**
[34] 2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.15.1.9

INTER-/INTRADEPENDENCIES:

Internal

- Appeal and Grievance
- Claims
- Compliance
- Member Services
- Provider Relations
- Quality Management
- Utilization Management

External

- Member
- NCQA
- Practitioners
- Providers
- State regulatory agency

Aetna Better Health

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