**Government Business Division**
**Policies and Procedures**

| Section (Primary Department) | | SUBJECT (Document Title) | |
|---|---|---|---|
| **Quality Management** | | **Member Complaints and Grievances - LA** | |
| **Effective Date** | **Date of Last Review** | **Date of Last Revision** | **Dept. Approval Date** |
| June 19, 2015 | ~~December 23, 2019~~~~December 29, 2020~~May 4, 2021 | ~~December 23, 2019~~~~December 29, 2020~~May 4, 2021 | ~~December 23, 2019~~~~December 29, 2020~~May 4, 2021 |
| **Department Approval/Signature :** | | | |

**~~Policy applies to health plans operating~~ in the following State(s). Applicable products noted below.**

| Products | | | | |
|---|---|---|---|---|
| ☒ **Medicaid/CHIP** | ☐ Arkansas | ☐ Iowa | ☐ Nevada | ☐ Tennessee |
| ☐ **Medicare/SNP** | ☐ California | ☐ Kentucky | ☐ New Jersey | ☐ Texas |
| ☐ **MMP/Duals** | ☐ Colorado | ☒ Louisiana | ☐ New York – Empire | ☐ Virginia |
| | ☐ District of Columbia | ☐ Maryland | ☐ New York (WNY) | ☐ Washington |
| | ☐ Florida | ☐ Minnesota | ☐ North Carolina | ☐ Wisconsin |
| | ☐ Georgia | ☐ Missouri | ☐ South Carolina | ☐ West Virginia |
| | ☐ Indiana | ☐ Nebraska | | |

## POLICY:

To acknowledge the right of the member or the member's authorized representative has a full and fair process to voice dissatisfaction with any aspect of operations, administration, care, services or the provision of behavioral health and/or health care services other than an "action".

To ensure the health plan follows a thorough and consistent process for addressing member complaints and grievances in a timely manner and provides a written resolution in accordance with regulatory state, federal, and accreditation standards, including the National Committee for Quality Assurance (NCQA).

To ensure the member complaint and grievance process is communicated and administered in a culturally and linguistically competent manner, including those with limited English proficiency and accommodating those individuals with disabilities consistent with the requirements of the American Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Age Discrimination Act of 1975, and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) in writing, oral, and TTY/TDD interpretation services.

To ensure the health plan maintains an electronic documentation system for documentation, monitoring and reporting data on complaints and grievances as expressed by a complainant orally or in writing to the health plan or a regulatory agency.

To monitor and report on member satisfaction with services and identify areas for improvement.

## DEFINITIONS:

**Action**:

1) The denial or limited authorization of a requested service, including the type or level of service;


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2) The reduction, suspension, or termination of a previously authorized service;
3) The denial, in whole or in part, of a payment for a service;
4) The failure to provide services in a timely manner, as defined by the State agency;
5) The failure to act within the timeframes provided in 438.408 (b);or
6) For a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right under 438.52(b) (2) (ii), to obtain services outside the network.

**Appeal** (Healthy Louisiana Contract Language) – A request for a review of an action. A formal request to an organization by a practitioner or member for reconsideration of a decision (e.g. utilization review recommendation, benefit payment, administrative action, quality of care or service issue) with the goal of finding a mutually acceptable solution.

**Appeal Procedure** (Healthy Louisiana Contract Language) – A formal process whereby a member has the right to contest an adverse determination/action rendered by an MCO entity, which results in the denial, reduction, suspension, termination or delay of behavioral and/or health care benefits/services. The appeal procedure shall be governed by Louisiana Medicaid rules and regulations and any and all applicable court orders and consent decrees.

Additionally, if a member contacts the Louisiana health plan telephonically and/or in writing expressing dissatisfaction with an adverse determination, reduction, suspension, termination, delay and or denial of a behavioral and/or health care benefit/services these member contacts will be considered appeals and not a complaints or member grievances and reported as such.

**Authorized Representative (NCQA definition):** An individual who acts on behalf of an individual through consent or under applicable law. An organization may establish procedures for determining whether an individual is authorized to act on behalf of one of its members. For urgent care decisions, an organization allows a health care practitioner with knowledge of the member's medical condition (e.g., a treating practitioner) to act as the authorized representative. The member may have anyone of those choice as their authorized representative.

**Complaint (NCQA definition):** ~~An oral or written expression of dissatisfaction. The expression of dissatisfaction can be with any aspect of the health plan or the provider's operation, provision of behavioral health and/or health care services, activities, or behaviors, other than an "action". Possible sources of complaints and grievances include, but are not limited to: quality of care, access, attitude and service, billing and financial issues, and quality of practitioner office site or failure to respect member's rights.~~ An expression of dissatisfaction with an aspect of the organization's operations or activities, including the actions of network providers and practitioners.
***Note:*** *NCQA's definition of complaint is inclusive of the CMS definition of "grievance."*


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**Grievance** (Healthy Louisiana Contract Language) – 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 or 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 (NCQA definition)**: A request for an organization to change a decision. ~~NCQA classifies all such requests as stages in the appeal process. Many states define the term "grievance" consistent with the NCQA definition of complaint; therefore both terms will be used interchangeably in this policy and procedure.~~

**Grievance Process** (Healthy Louisiana Contract Language) – the process for addressing enrollee's grievances.

**Grievance System** (Healthy Louisiana Contract Language) – 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 grievances system not just to the grievance process.

**Inquiry** – A member request for information or an issue that is resolved promptly during the initial telephone call by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the member.

**Mental Health/Substance Abuse (MH/SA) providers** (Healthy Louisiana Contract Language**)** – behavioral health professionals engaged in the treatment of substance abuse, dependency, addiction, or mental illness.

**Practitioner** (NCQA definition) – A licensed or certified professional who provides ~~health~~ medical care services or behavioral healthcare services. ~~. Practitioners are usually licensed as required by law.~~

**Provider** (NCQA definition) – An institution or organization that provides services such as a hospital, residential treatment center, home health agency or rehabilitiation facility. ~~for health plan members. Examples of providers include mental health, substance abuse, hospitals and home health agencies. NCQA uses the term practitioner to refer to the professionals who provide health care services, but recognizes that a provider directory generally includes both providers and practitioners and the inclusive definition is the more common use of the word~~.

**Note:** Definitions for complaints and grievances are state specific and do not necessarily reflect the exact NCQA definitions.

**PROCEDURE:**


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Healthy Blue maintains an electronic documentation system for the handling and resolution of complaints and grievances.
This includes:

1) Documentation of the substance of the complaint or grievance that is received by telephone, mail, fax, email, or in person and any actions taken;
2) Investigation and documentation of the substance of the complaint or grievance, including any aspect of clinical care involved;
3) Notification to members of the disposition of the complaint or grievance and the right to appeal, as appropriate;
4) ~~Standards for timeliness, including standards for clinically urgent situations;~~
5) ~~Provision of language services for the complaint or grievance process.~~

The health plan's grievance procedures and any changes thereto will be approved in writing by LDH prior to their implementation and will include at a minimum the requirements set forth in the Healthy Louisiana Contract.

At no cost to the member and upon request of the complainant, the health plan will make professional interpreter services assistance available for completing forms and TTY/TTD toll-free telephone services available at any stage in the complaint or grievance process. Member complaint and grievance process is communicated and administered in a culturally and linguistically competent manner, including those with limited English proficiency and accommodating those individuals with disabilities.

A member, provider, or authorized representative acting on the member's behalf, may file a grievance. The member or the provider may file a grievance either orally or in writing with LDH or Healthy Blue at any time.

No member or provider/practitioner will be penalized for filing a complaint or grievance. At no time will the health plan cease medically necessary care pending a complaint or grievance investigation.

If the member is not in agreement with original resolution decision, the member may submit a new grievance which will include a review by a different grievance representative that was not involved in the initial review.

The health plan will ensure that all members are informed of the grievance procedures upon enrollment. The health plan will provide to each member a member handbook that shall include descriptions of the health plans grievance and appeal procedures. Forms on which members or their authorized representative may file grievances, appeals, concerns or recommendations to the health plan shall be available and paper copies will be provided by Healthy Blue upon request.


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All applicable forms will be made available on the member website. Standards for timeliness, including standards for clinically urgent situations. Provision of language services for the complaint or grievance process.

The health plan will maintain accurate logs and records of all grievances in a manner accessible to LDH and available upon request to CMS. A copy of grievance logs and records of disposition of appeals shall be retained for ten (10) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the ten (10) 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 ten (10) year period, whichever is later. The contractor shall log, track and trend all grievances, regardless of the degree of seriousness or whether the enrollee expressly requests filing the concern. The health plan shall report on grievances and appeals to LDH in a manner and format determined by LDH.

The health plan shall electronically maintain data on grievances in accordance with the requirements outlined in the contract, to include, but not be limited to: member's name and Medicaid number, summary of grievances and investigation of and all evidence obtained during the investigation, date of filing; current status; date of review or review meeting; resolution information for each level of grievance, if applicable; ~~date of resolution at each level, if applicable;~~ and resulting corrective action. Reports with personally identifying information redacted will be made available for public inspection.

The health plan will ensure that the individuals who make decisions on grievances are individuals who were not involved in any previous level of review or decision-making, nor a subordinate of any such individuals, and who are health care professionals with appropriate clinical expertise, as determined by LDH in the treating the member's condition or disease:

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

Healthy Blue will be responsible for promptly forwarding any adverse decisions to LDH for further review/action upon request by LDH or the Healthy Blue member. LDH may submit recommendations to the MCO regarding the merits or suggested resolution of any grievance.

The health plan will educate staff concerning the importance of the grievance and appeal procedures and including the rights of the members and providers.

Time Limits for Filing:

The member shall be permitted to file a grievance at any time. ~~The~~[CL1][BD2] ~~member must be allowed sixty (60) calendar days from the date on the plans notice of action or inaction to request~~

~~an appeal (effective 2/1/2018). 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, with the member's written consent.~~

The Louisiana health plan will dispose of a grievance and provide notice, as expeditiously as the member's health condition requires, within the timeframes established in the Healthy Louisiana Contract:

- Healthy Blue will mail acknowledgement letters to the member or the member's authorized representative within five (5) business days of receipt of the oral or written complaint or grievance, except in instances where the resolution of the grievance occurs on the same day the grievance was received. Although the grievance is waived in this instance, the grievance will be reported on the monthly grievance log.
- Healthy Blue shall review the grievance and provide written notice to the enrollee of the disposition of a grievance no later than ninety (90) calendar days from the date Healthy Blue receives the grievance.
    - ~~The health plan may extend the timeframes by up to fourteen (14) calendar days if:~~
        - ~~The member requests the extension; or~~
        - ~~The health plan shows (to the satisfaction of LDH, upon its request) that there is need for additional information and how the delay is in the member's interest.~~
        - ~~If the health plan extends the timeframes, it must for any extension not requested by the member, give the member written notice of the reason for the delay within two (2) calendar days of the determination~~[CL3][BD4]

Written notification of the disposition of a grievance will be sent to the member or the member's representative.

The health plan will resolve a clinically urgent complaint or grievance as expeditiously as the member's medical or behavioral health condition requires but in no event greater than seventy-two (72) hours (three (3) calendar days) of receipt of the complaint or grievance.

1. National Customer Care (NCC) representatives receive inquiries over the telephone and log the inquiry into the appropriate electronic documentation system. NCC representatives are trained in customer relations, appropriate methods for resolving common inquiries and the importance of members' rights and responsibilities.

2. NCC representatives will attempt to resolve all inquiries at the time of the initial call; if they cannot resolve an inquiry to a member's satisfaction, the inquiry is then documented as a complaint or grievance.


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3. Calls received where Louisiana members are expressing dissatisfaction with an adverse determination, reduction, suspension, termination, delay and/or denial of health care benefit/services these member contacts will be considered appeals and documented as such. NCC will not document these expressions of dissatisfaction as a complaint or grievance.
3.
4. Complaints or grievances are also received in writing from the member or the member's authorized representative.

5. Upon receipt of a written member complaint or grievance, Document Management Control scans the written complaint or grievance into the member folder in the electronic documentation system and forwards the written complaint or grievance to the designated CCQM Member Complaint Specialist mailbox.

6. The CCQM Complaint Specialist retrieves the NCC representative documentation or the written documentation from the appropriate system or mailbox.
7. The CCQM Complaint Specialist codes the complaint or grievance in the system, based on state specific complaint or grievance coding requirements.

8. The summary of the complaint or grievance as documented by the NCC representative or the written statement of complaint or grievance from the member letter is transferred by the CCQM Complaint Specialist or the Health Plan Member Advocate/Complaint Specialist into the acknowledgement letter to identify the reason for the complaint or grievance.

9. The CCQM Complaint Specialist or health plan Member Advocate/Complaint Specialist generates and mails the state approved acknowledgement letter from the electronic documentation system within five (5) business days from receipt of the complaint or grievance; this letter is attached as a permanent record to the specific member complaint or grievance.

10. The CCQM Complaint Specialist forwards the complaint or grievance documentation to the appropriate health plan via the appropriate electronic documentation system.

11. The health plan Member Advocate/Complaint Specialist retrieves the complaint or grievance from the electronic documentation system and coordinates the process for resolution. This includes the initiation of the investigation, documentation of actions taken for resolution, member notification, assisting the member with filing and understanding the grievance process, and initiating an appeal, complaint or grievance as appropriate.


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12. Quality of Care complaints or grievances are referred by the health plan Member Advocate/Complaint Specialist to the health plan's Quality Management Department.

13. Quality of Care complaints or grievances are tracked and trended by provider/practitioner or other appropriate categories. In accordance with state specific, Healthy Blue's Quality of Care policies and Peer Review Processes, quality of care complaints or grievances are referred to the medical director as appropriate and reviewed at the time of re-credentialing of the provider.

14. The health plan Quality Management (QM) Leader oversees the member complaint and grievance process.

15. The health plan will track, trend, and analyze complaint and grievance data, separating results concerning behavioral health care, at a minimum in the following categories: (Bold * asterisk categories indicate LA Contract Reporting Categories)
    a. Quality of Care*
    b. Access to Care*
    c. Interpersonal Aspects of Care*
    d. Transportation*
    e. Behavioral Health*
    f. Pharmacy*
    g. Attitude and Service
    h. Billing and Financial issues
    i. Quality of Practitioner Office Site

16. Monitoring and analysis of complaint and grievance data is ~~conducted by CCQM and~~ reported to the Service Quality Committee and the Quality Management Committee ~~Quality Improvement Committee~~ on a quarterly basis.

~~17. On an annual basis, the health plan analyzes medical complaint and grievance data and provides a report to the Quality Improvement Committee and includes action plans, where appropriate.~~

~~18. On an annual basis, the health plan analyzes behavioral complaint and grievance data and provides a report to the Quality Improvement Committee and includes opportunities for improvement, implement interventions, and measure effectiveness of interventions.~~

~~19.~~17. All complaint and grievance documents are treated as confidential, placed in a secure location, and retained in accordance with the Records and Information Management policy.


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**REFERENCES:**

42 CFR 438.400 Grievance System; 42 CFR 431.200
Cultural Competency
Health Plan
Linguistic Services
Louisiana Medicaid State Contract
Member Appeals – Core Process - LA
Member Handbook (Member Rights and Responsibilities, Complaint and Grievances): By
Member Letters: By Health Plan
Member Privacy Rights, Section g. Complaints
Member Services Functions
National Committee for Quality Assurance; Standards and Guidelines for the Accreditation of Health Plan
Peer Review – LA
Provider Manual

**RESPONSIBLE DEPARTMENTS:**

**Primary Department**:
Quality Management

**Secondary Department**:
National Customer Care

**EXCEPTIONS:**

None

**REVISION HISTORY:**

| Review Date | Changes |
|---|---|
| 06/19/2015 | • New. Plan specify version made from Corporate version. Additional revisions made based on LA LDH feedback and final contract |
| 09/09/2015 | • Revised to include behavioral health requirements |
| 08/20/2016 | • For annual review<br>• Contract language updated under policy section<br>• Definitions placed in alphabetical order |


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| | • Updates throughout procedure section<br>• References placed in alphabetical order |
| 06/22/2017 | • Off cycle review<br>• Edits to procedure section for NCQA audit |
| 09/11/2017 | • For annual review<br>• Updates made throughout policy to reflect current contract language<br>• AGP reference changed to Healthy Blue |
| 10/15/2018 | • For annual review<br>• Authorized Representative definition added<br>• Edits to procedure section to include current contract language |
| 12/23/2019 | • Annual Review<br>• Edits within procedure sections<br>• Placed on updated template |
| ~~12/29/2020~~05/04/2021 | • Annual Review<br>• Revisions made throughout policy, definitions, and procedure to reflect 2021 NCQA standards |


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