Louisiana Medicaid Managed Care

Member Grievances Operational Guide

Federal Medicaid regulations (42 CFR § 438 Subpart F) require Medicaid managed care entities to administer a system for members to file grievances and BHSF is required to review reports on both the frequency and nature of grievances filed as well as the steps MCOs take to remedy such grievances as part of the State's quality strategy (§ 438.416). BHSF considers complete and accurate identification, tracking, investigation, analysis, and reporting of grievances by Louisiana Medicaid Managed Care Plans to be of paramount importance in **improving access to care, quality of care, and patient experience with care for Louisiana Medicaid enrollees.`**

The CMS definition of a grievance is "*an expression of dissatisfaction*" about any matter other than--

- denying or partially denying a **requested service**, including **type or level of service**;
- reducing, suspending, or terminating a previously authorized service;
- denying, in whole or in part, **payment** for a service; or
- failure to provide services in a timely manner (as defined by the State)

Examples of subjects for grievances include, but are not limited to, the quality of care or services provided; and aspects of interpersonal relationships, such as rudeness of a provider or employee; or failure to respect the member's' rights.

Louisiana Medicaid Managed Care Plans must:

- Document and treat as a grievance **all** oral and written expressions of dissatisfaction or complaints (hereafter called grievances) regarding any aspect of the operations, activities, or behavior of their Louisiana Medicaid MCO , its employees, its subcontractors, or its network providers, regardless of whether remedial action is requested and including member expressions of dissatisfaction received by and referred to the Plan by BHSF; (*See RFP 13.0, Bullet 4; 13.2.4.1*)
- Create a system in which any employee of the Plan who is made aware of an "issue", "problem", "complaint" or "grievance" can identify as a grievance, capture relevant details, log as a grievance and initiate further handling by the Plan according to its BHSF-approved grievance process; (*See RFP 13.0, Bullet 4*) The system should be designed to collect all information needed for completion of required monthly reporting to BHSF.
- Classify as an "action"/appeal—including actions of subcontractors (rather than a grievance)any --
  - Denial, partial denial, reduction, suspension, or termination of a requested **service,** or
  - Denial of **payment** for a service already received, or
  - Non-adherence to BHSF requirements for timeliness of prior authorization.

- Triage expressions of dissatisfaction relative to receipt of benefits and services within three working days of receipt to determine if an employee of the Plan or subcontractor has made an adverse benefit determination to deny or limit authorization of a requested service, including determinations based on the type or level of service [e.g., generic rather than brand name drug or alternative drug], requirements for medical necessity, appropriateness, health care setting, or effectiveness of a covered benefit or reduce, suspend or terminate a previously authorized service. **If an adverse benefit determination has been made, classify, handle, and report as an appeal rather than grievance.**
- If the expression of dissatisfaction or complaint involves an entity **other than** the Health Plan, a subcontractor of the Health Plan, or a network provider, referral should be made to the appropriate entity. Examples include other BHSF contractors and BHSF.
- Refrain from labeling complaints as inquiries and funneling into an informal review (*See RFP 13.0, Bullet 2*)
- Require that all subcontractors document and report to the Plan all oral or written expressions of dissatisfaction received by them for logging, processing and reporting;
- Investigate all grievances and **inform subject of grievance of the complaint** as part of the investigation; it is not sufficient for example, to merely change the member's PCP.
- Provide notice of final resolution of grievance to the member within two days of resolution but no later than 90 days of receipt); this notice may be via telephone, e-mail, or postal mail;
- Include easy to find links on the Louisiana Medicaid Managed Care Plan's "Home" page, "For Members" home page (if applicable) and "Forms" home page (if applicable) that inform members what they can do if they are not satisfied with an aspect of the Plan. (See RFP 13.2.4.2) ***It is not sufficient to have the information and forms in the electronic copy of the Member Handbook only as BHSF does not consider that to meet the requirement of "easily available. "*****Classification of "Reasons for Dissatisfaction" (Grievances)**
- Submit a monthly Member Grievance Report & Grievance Logs to BHSF
- Prepare for and attend meetings with Medicaid Executive Management to discuss Grievances and Appeals as required.
- Refer to the Health Plan's Quality Manager all grievances involving Quality of Care, Experience of Care, and Access to Care, following resolution for incorporation into the Plan's ongoing quality improvement program.
- Refer to the Health Plan's Medical Director all grievances involving Quality of Care (Medical Judgment, Failure to Listen to Member Concerns, Environmental Hazards, and Patient Safety).
- Refer to the Health Plan's Network Manager all grievances regarding network adequacy, following resolution for incorporation into the Plan's ongoing network development program.

Identification of Appeals

BHSF considers early and correct delineation between grievances and appeals to be of critical importance for the following reasons:

- If action has been taken resulting in an adverse benefit determination the timeframes for appeals differ
  - three working days or less for expedited appeal
  - thirty days for standard appeals
- An adverse appeal decision by the Medicaid managed care entity can be elevated to a State Fair Hearing while a grievance resolution cannot
- Louisiana State law R.S. -- 40: 1362 (2) (f)—requires BHSF to annually report the number of member appeals for each Medicaid managed care plan to the Legislature. The integrity and accuracy of this report requires that appeals be correctly identified and reported.

Health Plans shall incorporate into their member grievance procedures when receipt of benefit and services are at issue to determine if the Plan (including subcontractor) has denied a request. If the benefit or service requested by the member or by a provider on behalf of a member has been denied, the grievance shall be reclassified as an appeal and handled/reported as such.

Expressions of Member Dissatisfaction Referred to Plan by BHSF

BHSF provides the option to members to report "issues or complaint about Bayou Health" directly to the State by completing an electronic form that can be linked to from the Member website https://bayouhealth.com/LASelfService/en_US/home.html .

In addition to the Bayou Health webpage, expressions of member dissatisfaction may be received by DHH through the main DHH website, phone calls and e-mails to BHSF and other DHH employees and the Medicaid Customer Service Hotline. All member expressions of dissatisfaction (grievances) and contacts relative to adverse benefit determinations (appeals) will be promptly referred to the Health Plan Grievance and Appeals Coordinator for identification as a grievance or appeal, logged, investigated and reported. The date received is the date the Health Plan received the referral from BHSF. The source of these grievances and appeals should be reflected as "BHSF" when completing the Member Grievance Detail Log.

As part of BHSF monitoring and oversight of Member Grievances and Appeals, monthly reports will be reviewed upon receipt to verify that all member issue/complaints referred to the Plan by BHSF have been logged and treated as a grievance or appeal if applicable. If not a grievance or appeal (e.g., request is for information but no expression of dissatisfaction) that should be notated in the Resolution and the case excluded from the total.

Member Request to Change Bayou Health Plans

Members can request disenrollment from MCO "for cause" at any time. In the event that a member requests disenrollment outside of the ninety day choice period or annual open enrollment, BHSF may require that the Plan's grievance process first be exhausted if the cause is one of the following:

- Poor quality of care;
- Lack of access to MCO core benefits and services covered under the contract;
- Lack of access within the MCO to providers experienced in dealing with the member's healthcare needs;
- Any other reason deemed to be valid by BHSF.

Member requests for disenrollment are submitted to the Enrollment Broker and the date of the request begins the 30 day clock for the MCO to address the member's grievance. These requests are routed through the Health Plan Compliance Officer to the MCO for research and resolution. MCOs must advise their DHH Compliance Officer of the grievance resolution prior to the 30th day or the member's request to disenroll for cause will be approved.

Monthly Grievance Reporting

The monthly Grievance Report shall be submitted to BHSF by the 15th of the month reflecting all activity from the first day through the last day of the previous month (Report Month). The complete submission consists of a Cover Letter and Grievance Detail Logs.

Grievance Report Cover Letter must include

- A summary of all **new** grievances received from the first day of the report month through the last day of the report month, the number of grievances **resolved** during the report month, the number of grievances **still pending** at the end of the report month, and grievances that **pended beyond 90** days at any time during the report month.
- An **analysis** of all resolved grievances including trends (upward or downward) and any plans for interventions to address the issues
- The name of person to contact for follow-up questions about the contents of the report and their contact information.

Grievance Detail Logs shall be completed in Excel with the following printing specs: 8 ½ x 14, .25 margins, landscape orientation, with a header which shall include the Health Plan Name and Reporting Period. A **separate worksheet/log** shall be prepared for each of the following categories (total of 6):

- **Access to Care (A)**
- **Quality of Care (Q)**
- **Interpersonal Aspects of Care (I)**
- **Medical Transportation (T)**
- **Pharmacy (P)**
- **Not Grievance or Appeal**

#	Date	Medicaid ID	Source	Subject	Narrative Explanation of Dissatisfaction	BHSF Category	Narrative Investigation & Resolution	Date Resolved
UN YYMM	2/1/15	xxxxxxxxxxxx	Member Parent Spouse Provider etc.	Plan Contractor Provider (show NPI)				

Fields to Be Displayed on <u>Printed Reports</u>

- 10 Character Internal **Tracking #**
  - First two characters
    - AE for Aetna
    - AG for Amerigroup
    - AC for AmeriHealth Caritas
    - LH for Louisiana Healthcare Connections
    - UN for United
  - Four characters YYMM (Year and Month)
  - Four character sequential number as assigned by Plan

  BHSF will use this tracking # to identify for follow-up questions and comments.
- **Date** First Rec'd
- 13 digit **Medicaid ID#** of member
- **Source** (this may be member, family member (specify relationship such as mother, spouse) provider, BHSF, or other (specify)
- **Subject** of Grievance (Plan) (Contractor Name) (Provider NPI if a Network Provider—name of provider should be shown in narrative rather than this field)
- **Narrative Explanation of Dissatisfaction** [three to five sentences in length including the most relevant details and requested resolution/relief sought by member *if a provider, include provider name*]
- **Category** (Short Title as Defined by BHSF—See Below for Full List)
- **Summary of Investigation and Resolution** Include the date investigation of dissatisfaction began and, **as applicable**:
  - Screening to determine if PA decision has been issued by the Plan or a subcontractor,
  - Rationale for considering as grievance rather than appeal if a denied benefit or service is at issue,
  - Notification to subject of grievance and their response,
  - Any request for and review of medical records,
  - Communication method (s) of final disposition (telephone and/or postal mail) to member,
  - Whether referral has been made to Quality Management Section, Network Management, Case Management, Provider Education, the Medical Director et.al.;
- **Date Resolved** Date resolved is the date of written confirmation to member.

Categories for Grievance Logs

Dissatisfaction with Access to Care

Office Wait Time *Narrative Explanation of Dissatisfaction* should include the length of time, provider type, provider name/NPI and any other relevant details

Time to Get an Appointment *Narrative Explanation of Dissatisfaction* should include the length of time in days, weeks, or months, provider type, and any other relevant details

Inability to Find a Provider in Area *Narrative Explanation of Dissatisfaction y* should include name of city or town, parish and zip code, provider type and any other relevant details

Inability to Obtain Requested Service *Narrative Explanation of Dissatisfaction* should include provider type, provider name/NPI, service requested (*e.g.* prescription (include what for if stated), referral (include type of referral), MRI, and any other relevant details. *Include here also issues such as DME provider demanding oxygen machine back due to alleged non-payment by MCO.*

Administrative Barrier to Access—Eligibility *Narrative Explanation of Dissatisfaction or Summary of Investigation and Resolution* should indicate the entity(ies) whose system is not reflecting member's eligibility (BHSF, Health Plan, subcontractor including PBM), date corrected.

Administrative Barrier to Access—Plan ID Card *Narrative Explanation of Dissatisfaction* should include

Provider Administrative Barrier to Access—Incorrect TPL Information *Narrative Explanation of Dissatisfaction* should include provider type, name /NPI a description of the barrier

Provider Administrative Barrier to Access—Demanding Payment *Narrative Explanation of Dissatisfaction* should include provider type, name /NPI a description of the barrier (e.g. would not see member because of unpaid balance, requesting payment for non-covered service as condition of receiving a covered service, suggesting member pay "up front")

Provider Other Access to Care *Narrative Explanation of Dissatisfaction* should include the provider type, provider name/NPI, description of barrier to access/inability to obtain service, and any other relevant details

Involuntary Dismissal by Provider

Provider Administrative Barriers to Access *Narrative Explanation of Dissatisfaction* should include provider type, name /NPI a description of the barrier (*e.g.* appointment required, or missing too many previously scheduled appointments unable to exchange knee brace that was wrong size) and the service

Dissatisfaction with Quality of Care

Report non-emergency medical transportation separately

Medicaid Judgment & Advice *Narrative Explanation of Dissatisfaction* should include name of provider/NPI and the diagnosis or medical advice with which the member takes exception, and any other relevant information.

Failure of Provider to Listen to Member *Narrative Explanation of Dissatisfaction* should include name of provider/NPI, a description of the provider's failure to listen to member's concerns, and any other relevant information.

Environmental Hazards *Narrative Explanation of Dissatisfaction* should include name of provider/NPI, a description of the (*e.g*., dirty or unsanitary office, crowded office) and any other relevant details.

Patient Safety *Narrative Explanation of Dissatisfaction* should include name of provider/NPI, a description of the action or conditions (*e.g*. physician not wearing gloves, sneezing on patient, rough or careless handling,) and any other relevant details.

Other Quality of Care *Narrative Explanation of Dissatisfaction* should include the provider type, provider name/NPI, description of concern with quality of care, and any other relevant details. *Include here dissatisfaction with being seen by Nurse Practitioner rather than Physician*

Dissatisfaction with Interpersonal Aspects of Care

Classify as **Rudeness, Lack of Concern**, **Violation of Confidentiality or Privacy, Failure to Respect Member Rights, Alleged Discrimination, Lack of Interpretation/Translation Services, Other**

Narrative Explanation of Dissatisfaction should include the subject of dissatisfaction:

- **Network Provider--** name of provider/NPI, provider type, a description of the perceived action and any other relevant details;
- **Subcontractor--** name of subcontractor, service(s) they provide description of the perceived action and any other relevant details
- **Health Plan—**employee name if known and job title, a description of the perceived action and any other relevant details

and

Rudeness -- *Narrative Explanation of Dissatisfaction* should include a description of the perceived rudeness and any other relevant details.

Lack of Concern *Narrative Explanation of Dissatisfaction* should include a description of the perceived lack of concern and any other relevant details.

Violation of Confidentiality or Privacy *Narrative Explanation of Dissatisfaction* should include a description of the violation of confidentiality or privacy (*e.g.*, revealing personal details in the presence of other patients, release of information without consent, provider sending inappropriate text messages) and any other relevant details.

Failure to Respect Member Rights *Narrative Explanation of Dissatisfaction* should include a description of (e.g., member receiving bill/amount), the provider type, provider name/NPI if applicable and any other relevant details

Alleged Discrimination

Translation/Interpretation Services

Dissatisfaction with Medical Transportation

Because of the high volume of complaints related to non-emergency medical transportation (NEMT), these grievances/complaints should be reported separately to assist in aggregating for global analysis across all Health Plans by BHSF. The issue may be either timeliness or service level. **NEMT Subcontractors must maintain the data for complaints received directly by them and Health Plans shall obtain and include, along with transportation-related complaints received directly by the Plan.**

Subject field for NEMT Report should include the name of the Transportation "Company" rather than the Plan subcontractor for NEMT or the name of the driver. The driver's name should be obtained if possible and included in the Narrative field.

Subcategories for the Transportation Grievance Report **Category** Field are:

- Missed Appointment
- Late for Appointment
- Late Being Picked Up **after** Appointment/Not Picked Up
- Driver Arrived Before Scheduled Time
- Unsafe Driving
- Condition of Vehicle (ex. Broken air conditioner, balding tires, shaking, dirty, smelling of alcohol)
- Driver Professionalism (inappropriate language, rude, unkempt, excessive stops for gas)
- NEMT Subcontractor (customer service representative rudeness, policies on notice, refused to schedule)

Dissatisfaction with Pharmacy Benefits

Because of the volume of grievances relative to the Pharmacy Program, those "events" that involve the Health Plan's PBM, contract Pharmacy providers, and Pharmacy Lock-In should be reported on the Pharmacy Benefit Detail Log to assist in aggregating and global analysis across all Health Plans by BHSF.

The Pharmacy Benefits grievances are classified as **Pharmacy Benefit Manager Issue**, **Pharmacy Lock-In**, and **Network Pharmacy Issue.**

- **Pharmacy Benefit Manager Issue *Narrative Explanation of Dissatisfaction* should include the name of provider/NPI and the Point of Sale (POS) denial, clinical edit, and/or other relevant details of the pharmacy claim.**
    - Early refill denial
    - Medication is not covered
    - Pharmacy billing/dual billing/other coverage issue
    - PA denial/pharmacy override denial
    - Pharmacy claim denial due to clinical edit(s)

- **Pharmacy Lock- In** *Narrative Explanation of Dissatisfaction should include the name of provider/NPI and a description of the pharmacy Lock-In issue.*
    - Lock- In provider choice denied
    - Lock- In pharmacy out of stock of medication
    - Lock- In removal not granted
    - Lock-In provider declines participation in Lock-In for member and/or plan
    - Lock-In provider no longer enrolled in plan

- **Network Pharmacy Issue** *Narrative Explanation of Dissatisfaction* should include the name of provider/NPI and a description of the issue occurring at the network pharmacy.
    - Pharmacy customer service issue
    - Pharmacy reimbursement issue
    - Pharmacy claims processing issue
    - Pharmacy software vendor issue
    - Plan requires use of a specialty pharmacy provider