

SECTION S: MEMBER GRIEVANCES AND APPEALS

S.1 Grievance and Appeals Systems and Process

S.1 Provide a flowchart (marked as Chart C) and comprehensive written description of your member grievance and appeals process, including your approach for meeting the general requirements and plan to:

- *Ensure that the Grievance and Appeals System policies and procedures, and all notices will be available in the Member's primary language and that reasonable assistance will be given to Members to file a Grievance or Appeal;*
- *Ensure that individuals who make decisions on Grievances and Appeals have the appropriate expertise and were not involved in any previous level of review; and*
- *Ensure that an expedited process exists when taking the standard time could seriously jeopardize the Member's health. As part of this process, explain how you will determine when the expedited process is necessary.*

Include in the description how data resulting from the grievance system will be used to improve your operational performance.

Amerigroup Louisiana (Amerigroup) has designed grievance and appeals systems to provide members with fair, easy-to-follow processes for bringing and resolving problems and issues. Our systems provide members with several levels of recourse in accordance with State Contract requirements and federal and State laws and regulations. They are fully compliant with 42 CFR Part 438, Subpart F, and all policies and procedures will be approved in writing prior to implementation. Employees receive continuous training on the grievance and appeals process, and the rights of members and providers.

Amerigroup's averages are
100 percent
compliant with DHH
resolution standards. 

Amerigroup's local Louisiana Quality Management staff researches and resolves grievance and appeals issues, treating members in a professional, respectful, and timely manner. Since we began our programs in Louisiana in 2012, Amerigroup has maintained a record of adhering to the DHH standards of grievance resolution within 90 days, appeal resolution within 30 days, and fair hearing decisions within 60 days.

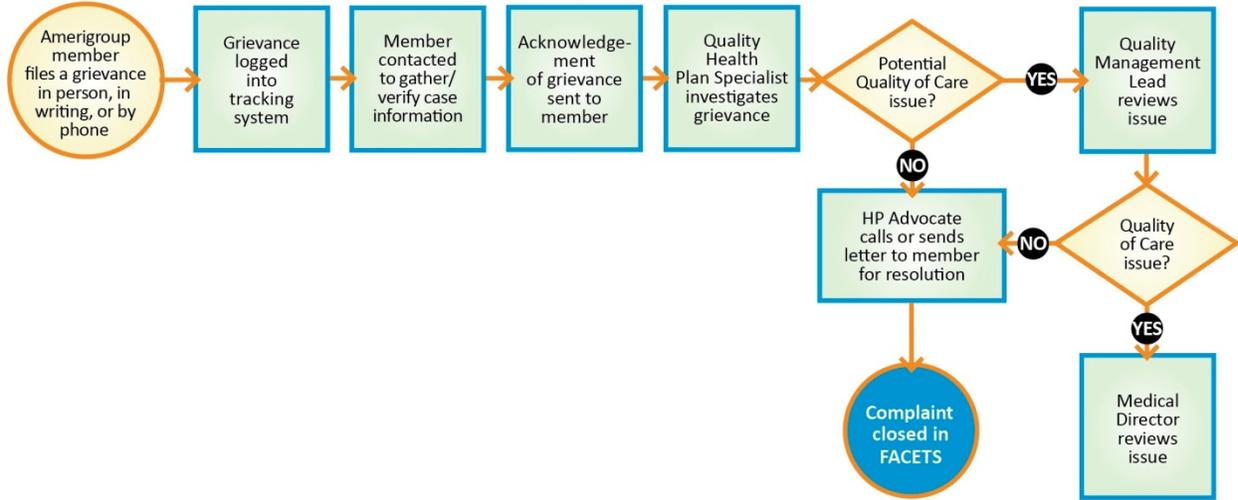
In fact, our performance for 2013 is well above DHH requirements:

- Grievances resolved within 4.97 days (requirement is 90 days)
- Appeals resolved within 19.93 days (requirement is 30 days)
- Fair hearings resolved within 40.37 days (requirement is 60 days)

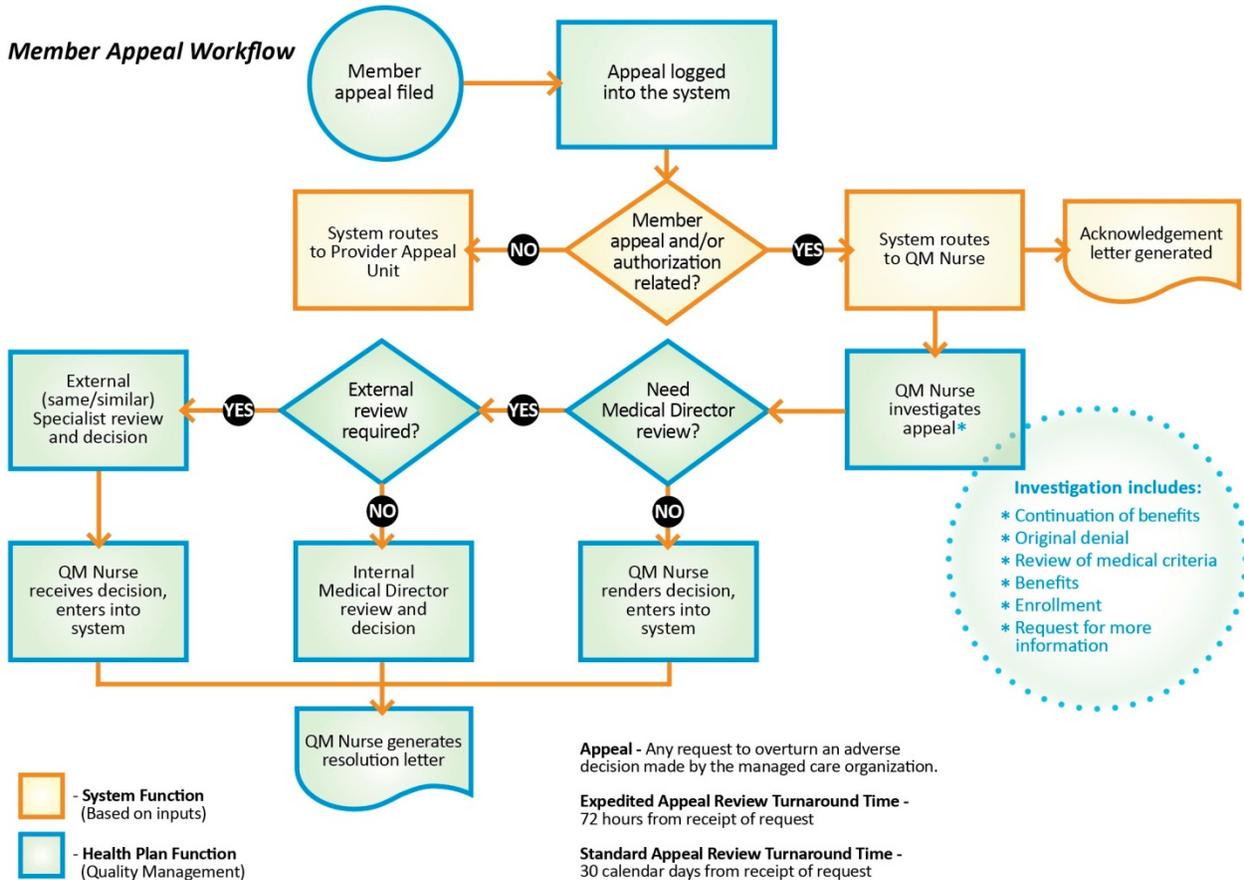
Amerigroup has dedicated resources supported by detailed policies and procedures ensuring that the all members, providers and staff are aware of the importance of the Grievance and Appeal process. Emphasis is place on adhering to requisite timeframes and notification requirements with the end goal of members having an avenue for fair and equitable grievance reporting and resolution.

Figure S-1.1 Grievance and Appeal Process (CHART C)

Member Grievance Workflow



Member Appeal Workflow



Grievance Definition

Consistent with DHH requirements, Amerigroup defines a grievance as an expression of dissatisfaction about any matter other than an action. This may include dissatisfaction related to the quality of care rendered or available, rudeness of a provider or employee, or the failure to respect the member's rights. Members can file a grievance within 30 calendar days of the occurrence. The term grievance and complaint are used interchangeably.

Registering a Grievance or Appeal

Amerigroup's grievance and appeals process provides multiple options for individuals to reach us and register their concerns. Members or their representatives may file a grievance or appeal by a toll-free telephone call, in writing, through email, or in person. A provider may file a grievance on behalf of a member, as well as advocate and advise on behalf of the member, with the member's written consent.

When filing a grievance or appeal by telephone, individuals call Amerigroup's National Call Center. Our representatives fully document grievances and appeals by:

- Claims vs. medical necessity appeals
- Member vs. provider appeals and grievances
- Expedited vs. standard appeals and grievances

Representatives know how to distinguish between grievances and appeals, and document all pertinent and required information. If the member needs interpreter services, the representative will initiate a three-way call with an interpreter to support more than 200 languages. Interpreter service is free to our members. For those with hearing issues, video relay and TTY/TDD assistance is available.

Once a grievance has been filed and logged, the member is contacted by a member advocate to review details of the grievance and gather any missing or additional information. Then, the grievance is referred to the Health Plan specialist for review. If the grievance is a potential quality of care issue, it is referred to Quality Management with final review by Amerigroup's Chief Medical Officer. If the grievance is not based on quality of care, the Health Plan specialist investigates the matter and works with the member for a resolution.

Tracking

We maintain all key information about complaints in our FACETS and appeals in our PEGA systems.

Complaints received in writing are electronically imaged, along with correspondence and other hard-copy information, and can be easily accessed through FACETS. Through this system, we track complaint data elements such as:

- Date received/resolved
- Identification of the individual filing the complaint (reported through a drop-down box indicating member, provider, or person acting on behalf of the member)
- Identification of Amerigroup employee recording the complaint
- Nature of complaint (reported through a drop-down box)
- Disposition
- Corrective action required

Appeal Tracking

Appeals are tracked through PEGA, a recognized industry leader in business process management, business rules, and customer relationship management. PEGA technology is an enterprise solution for managing Medicaid appeals, reducing many of the manual and human processes that go along with it, and thereby reducing error and increasing timeliness and efficiency. The application interfaces with our other systems, providing real-time access to member and provider information, including membership, eligibility, service, and claim payment details. PEGA has the capability to track an appeal by member, provider, authorization, and/or claim, as well as act as the central repository for all segments of the appeal, regardless of whether it is related to benefit coverage.

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Grievance and Appeal Resolution

The standard for grievance resolution is 90 days, and for appeals 30 days from the date of receipt. This time frame may be extended up to 14 calendar days for appeals if the member requests an extension or Amerigroup shows, to DHH's satisfaction, that there is a need for additional information and that the delay is in the best interest of the member. If there is an extension, Amerigroup will notify the member in writing. Expedited appeals and grievances must be resolved within 72 hours.

Member Notification

Once we receive a complaint or appeal, we send an acknowledgement letter within three business days. We monitor the time it takes to resolve each complaint or appeal, and track the acknowledgement and resolution letters, notes, nature of complaint or appeal, and turnaround times. This acknowledgement is in addition to contact at the time of filing if additional case information is needed.

Appeal Definition and Filing

Consistent with DHH and NCQA requirements, Amerigroup defines an appeal as a request for review of an action. Our policies and procedures address DHH requirements for the following:

- Denial or limited authorization of a requested service, including its type or level
- Reduction, suspension, or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service
- Failure to provide services in a timely manner
- Failure of Amerigroup to act within the required time frames

PEGA records and tracks appeals, and generates notifications. A member may file an appeal within 30 days of the date on the Amerigroup Notice of Action (NOA). A provider may file an appeal on behalf of a member, as well as advocate and advise on behalf of the member, with the member's written consent. Amerigroup will not take punitive action against a provider who supports a member appeal. Amerigroup will consider the member, representative, or estate representative of a deceased member as parties to the appeal.

An appeal may be filed in writing or orally. Amerigroup will acknowledge the appeal within three business days. Before and during the appeals process, Amerigroup will allow the member and/or authorized representative to examine the case files, including medical records and any other relevant documents and records, and to present evidence and allegations of fact or law in person, as well as in writing.

Using State-approved templates, we will send an appeal resolution letter within two business days to a member and/or authorized representative. The written notice will include a description of actions taken, the reason for them, the member's right to request a State Fair Hearing for medical necessity, the process for filing for a fair hearing, and other information as required by DHH.

Expedited Appeals

An expedited appeal can be requested if the turnaround time for a standard appeal could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Medical judgment is used in reviewing all requests for medical appeals. Amerigroup staff may expedite an appeal when they determine that one of these criteria have been met and an expedited request has been made by a member, or representative or provider making a request on behalf of a member.

No punitive action will be taken against anyone who requests an expedited resolution. Expedited appeals may be requested either orally or in writing.

Amerigroup will resolve expedited appeals and provide notice as the member's health condition requires, and within State-established time frames not to exceed 72 hours after we receive the appeal, unless this time frame is extended according to DHH guidelines. We will provide written notice of the disposition of the appeal to the member and/or the authorized representative, and make reasonable attempts to provide oral notice as well. Should a request for expedited resolution be denied, we will transfer the appeal to our standard appeals process and provide written and oral notice to the member within two calendar days. If a member does not agree with the decision, he or she may request a State Fair Hearing.

Expedited Appeal Process

Amerigroup has comprehensive policies and procedures for managing expedited appeal requests. Upon receipt of a request, staff performs the following steps:

- The request is logged into our information system, including the document management system, if received in writing.
- The Appeals Nurse researches the information and documents the issue in a case file. Additional information is requested as needed.
- The Chief Medical Officer, or designee, is presented the case within 24 hours of receipt, along with notice that it is an Expedited Appeal. The Appeals Nurse confirms that the Chief Medical Officer, or designee, is not the same physician involved in the initial adverse determination or subordinate to the initial reviewing physician.
- The Chief Medical Officer, or designee, makes a determination to approve or deny the request within 72 hours.

If the member requests an extension or Amerigroup shows, to DHH's satisfaction, that there is a need for additional information and that the delay is in the best interest of the member, the time frame will be extended for up to 14 calendar days. If there is an extension, Amerigroup will notify the member in writing.

Review of Appeals

The Quality Management Department in our Louisiana health plan will investigate and resolve all grievances and appeals. Amerigroup's policies and procedures assure that individuals making decisions have appropriate expertise and were not involved in previous reviews.

The Chief Medical Officer identifies appropriate reviewers based on the clinical conditions involved in the appeal. Potential reviewers include other Amerigroup Medical Directors, network practitioners, or

contracted external independent review organizations with expertise in treating the member's condition or disease if the case involves:

- An appeal of a denial based on lack of medical necessity
- A grievance about denial of expedited resolution of an appeal
- A grievance or appeal involving clinical issues

Grievance and Appeal Notices

All grievance and appeals notices are written and meet the timing, language, element, and format requirements contained within Section 13 of the RFP and 42 CFR §438. Notices are National Committee for Quality Assurance (NCQA) compliant and reviewed in relation to CHISOLM requirements.

Amerigroup has all grievance and appeals written materials available in English, Spanish, and Vietnamese, and will translate materials into other languages upon request. Amerigroup provides interpretation services at no charge for all written member materials in any language. We also offer materials in additional formats at no charge, including large print, audio recording, and Braille, to accommodate members with visual or hearing impairments, disabilities, or special needs. All notices of action are developed in accordance with State guidelines and reviewed by DHH prior to use.

Assisting Members in Filing a Grievance or Appeal

Members, providers, and subcontractors learn about the grievance and appeals process through various media. All materials will be subject to review and approval by DHH. As with our affiliates' practices in 15 other states, we notify providers and subcontractors of all appropriate information when they enter a contract with Amerigroup. Other points of notification will include:

- Member handbook, provider manual, and updates
- Member and provider websites
- Individual notification to members and providers, such as adverse decision
- Member and provider newsletters
- Forms for filing a grievance or appeal

Grievance and appeal forms are available to members via the member website. Amerigroup will provide forms upon request through the toll-free member line and in the Notice of Action letters for denial of services.

Our Call Center Representatives are trained to assist members in completing forms for the grievance and appeals process. They work with the member to review the steps, requirements, and timeframes associated with the process. They also provide interpreter, video relay service, and TTY/TTD assistance. In all cases, we support the member throughout these processes.

The grievance specialist will be responsible for investigating and leading the resolution of Amerigroup member grievances, and serves as a liaison between the member and health plan. The QHP specialist has a thorough understanding of the Louisiana health care environment, including the unique challenges facing the financially vulnerable, elderly, and people with disabilities. As appropriate, they will interact with members, their caregivers, or advocates throughout the grievance and appeals process, verifying that members understand their rights and the decisions made. In our experience, designating a specially trained staff member to work closely with members and advocate on their behalf throughout this process results in their greater satisfaction, as well as prompt resolution of grievances and appeals. In all cases, the QM Leader facilitates the process, *coordinating language assistance where needed and making sure all materials are in the member's primary language.*

Tracking and Response

Our grievance and appeals process is supported by robust information systems, whose tracking and reporting capabilities, together with clearly delineated policies and procedures, including all appropriate timelines, help us facilitate a timely review and response to member inquiries.

All actions are noted in the appropriate transaction system—FACETS for grievances and PEGA for appeals—and the appropriate system automatically generates Notice of Action (NOA) letters to the provider and the member, informing them of the denial or reduction of requested services. The NOA will provide the member with information about filing an appeal or requesting a fair hearing. It is a formal communication that informs the member and/or representative of the decision, reasons for the action, and the options available for additional review. All NOAs will be developed in accordance with State guidelines and reviewed by DHH prior to use.

Amerigroup will adhere to the requirement for promptly forwarding any adverse decisions to DHH for further review/actions upon request by DHH or the member.

Coordinating with the State for Member Appeals

Amerigroup will strive to resolve the appeal in a fair and equitable manner, recognizing that on occasion an adverse decision may be rendered. In those cases, a member has the right to request a State Fair Hearing after they have exhausted our appeals process and within 30 calendar days of the written notice of our determination. Parties to the State Fair Hearing include Amerigroup, the member, and his or her representative, or the representative of a deceased member's estate. If a member or authorized representative requests a Fair Hearing, Amerigroup will promptly provide all necessary information and support documentation on the appeal investigation and findings to the Division of Administrative Law. The Amerigroup Chief Medical Officer will serve as the State's contact for Fair Hearings.

Amerigroup agrees to be bound by the decision of the State Fair Hearing Officer and acknowledges the following requirements:

- 438.10(g)(1) — Enrollees must be notified of grievance, appeal, and fair hearing procedures and time frames.
- 438.414 — The MCO must provide information about the grievance system to all providers and subcontractors at the time of contract execution.
- 431.220(5) and 431.200 (b) — The MCO provides an opportunity for a State Fair Hearing if action is taken to suspend, terminate, or reduce services.

We actively participate in the State Fair Hearing process, providing medical records and other documentation at our expense. We also present evidence at Fair Hearings, and if necessary, we arrange non-emergency transportation for members who wish to attend but do not have transportation. For certain appeals, we continue to provide benefits to our members according to DHH regulations.

Should Amerigroup or the State Fair Hearing process reverse a decision to deny, limit, or delay services not furnished while an appeal is pending, we will authorize the disputed services promptly and as expeditiously as the member's health condition requires in accordance with Section 13.8. of the RFP.

Grievance/Appeal Records and Reports

Amerigroup closely monitors complaint and appeal volumes, and daily aging reports help us achieve timely resolution within State requirements. Review and analysis of complaint, grievance, and appeal data is an integral part of Amerigroup's Quality Management program. In addition to preparing, reviewing, and submitting required reports to the DHH, our Quality Management Department conducts a comprehensive review of complaint, grievance, and appeal data each quarter. It focuses on identifying issues, problems, and trends for presentation to the Quality Management Committee.

The primary report generated for review aggregates complaint, grievance, and appeal data across a number of key dimensions, including type of complaint or grievance, appeal action, and disposition. All report data is aggregated to protect member privacy.

We perform a root-cause analysis to identify drivers of increased complaints, grievances, and appeals, as well as any specific trends in the types of issues received. We analyze results for review discussion, and development of action plans for improvement, including member or provider education, and examining internal processes, and/or development of a formal internal improvement initiative.

Since we partnered with Louisiana in 2011, Amerigroup has worked in concert with DHH to identify areas for improvement. For example, from 2012 to 2014, we worked collaboratively to identify and approve revision of the appeals, grievances, and State Fair Hearing template to reflect accurate documentation of the totals, categories, and decisions.

Results are analyzed for review, discussion, and development of action plans for improvement. 

Another example of using analyzed data to improve performance is activities undertaken to identify the cause of a high number of abandoned calls. In May 2012, the average rate of call abandonment was 9.73 percent – above the contract standard of five percent. In researching causal factors, it was determined that the LogistiCare (a non-emergency transportation vendor) Customer Service Representatives were not logging in and out of the queues correctly, thus resulting in abandoned calls. LogistiCare found that this issue resulted from representatives not switching their phones to an “auxiliary out” mode to make them available for incoming calls. LogistiCare immediately retrained and instructed the representatives on the correct handling of the system.

Reporting to DHH

Every month, Amerigroup will electronically provide DHH with a report of grievances and appeals. At minimum, the reports will contain member name and Medicaid number, summary of grievances and appeals, date of filing, current status, resolution, and resulting corrective action. A redacted version of the monthly report will be made available for public inspection.

Record Retention

All records and reports related to grievances and appeals will be retained for six years. If any litigation, claim negotiation, audit, or any other action involving the documents or records occurs before expiration of the six-year period, the records shall be retained until completion of the action and resolution of issues or until the end of the regular six-year period.

Improving Performance

Amerigroup's Quality Management Manager tracks all grievances and appeals to identify quality improvement opportunities. Information from member grievances and appeals, as well as provider complaints, is used throughout Amerigroup to improve the services we provide to members, providers, and our State customers. This includes those filed formally or through informal methods, such as member forums or on-going provider training sessions. That data and information is used in improving clinical performance, identifying and resolving quality of care issues, and improving the quality of the credentialing process and member services. Grievance and appeal information is provided to our Health Education Advisory Committee, which focuses on member relations and their experiences with the services we provide.

Amerigroup uses the data and information to identify operational changes resulting in better service to our members, providers, and the State of Louisiana.

Better Service of Member Needs

- A parent submitted an appeal for cochlear implant batteries when the initial request was denied for exceeding the limit of 12 batteries per year. The member, aged 12 at the time, has a cochlear implant, and the requested batteries were for that system. The member uses three batteries at a time and must change them every one to three days. There was nothing in the Bayou Health Plan Contract specific to cochlear implant batteries—only hearing aids. Our system links the batteries to the hearing aid section. The Chief Medical Officer approved the cochlear implant batteries.
- A member had been enrolled in the same St. Jude treatment protocol since December 2010, and the Plan was paying for services as an out-of-network benefit. The appeal was for services to be provided in-network. The initial request was denied as services were available in-network. The Chief Medical Officer determined that this met Continuity of Care and approved a Single Case Agreement for the member to continue care at St. Jude at the in-network rate as the treatment protocol is not available in Louisiana.
- During the first six months of 2012, there was an increase in the quantity and quality of grievances filed regarding LogistiCare, the vendor for non-emergency transportation in Louisiana. In August 2012, LogistiCare senior leadership and Louisiana staff met to address the escalating number of grievances, which resulted in a Corrective Action Plan (CAP). Though all of the elements in the 2012 CAP were resolved, LogistiCare grievances continued, and the quantity peaked at 56 in the second quarter of 2013. LogistiCare worked with the National Account Manager and Amerigroup's Quality Management Department and designated a Manager for the State of Louisiana who set in place various processes to address the nature of the grievances. LogistiCare has shown marked improvement; in June 2014, LogistiCare received only three complaints.

Better Use of Tools and Resources

Amerigroup's work to transform our Medicaid appeals management system has been recognized with an industry award, the Health Care Business Transformation Award, from Pegasystems, Inc. This was a joint project among several areas in the Medicaid business and IT that produced an exceptional product. PEGA is now used across all authorization and claim appeals to engage providers and members. The system streamlines these critical functions, improving interactions with members and providers alike, while facilitating regulatory compliance.

Better Quality of Services

In November 2012, Pharmacy was carved into Bayou Health. During the first half of 2013, member appeals rose to more than 700, with Pharmacy appeals comprising more than 300 of them. April Pharmacy appeals peaked at 108. The data was analyzed and we determined that providers were being given 24 hours to supply additional information supporting medical necessity. If the necessary information was not received, the requested medication was denied. The Chief Medical Officer, Pharmacy staff and Quality Management staff worked in tandem to review the policy and determined that providers would be given 72 hours to respond to additional information requests. Additionally, internal procedures were realigned to 72 hours. By December 2013, the number of pharmacy related appeals had dropped to 15. Having the data to perform a root cause analysis allowed Amerigroup to re-engineer a process in the best interests of providers and members.