POLICY AND PROCEDURE

DEPARTMENT: Appeals and Grievance	**REFERENCE NUMBER:** AZ.AG.07
EFFECTIVE DATE: 10/01/2015	**POLICY NAME:** Member Grievance and Provider Complaint Process
REVIEWED/REVISED DATE: 11/21/2022, 05/23/2023, 10/17/2023	**RETIRED DATE:** N/A
PRODUCT TYPE: Arizona Medicaid	**PAGE:** 1

SCOPE:
This policy applies to all directors, officers, and employees of Centene Corporation for its Arizona health plans (the "health plan").

PURPOSE:
To ensure compliance with all federal and state laws, regulations, and policies related to timely resolution of member grievances and provider complaints (collectively referred to as "grievances").

POLICY:
The Health Plan maintains internal procedures to ensure grievances are managed in a courteous, responsive, effective, and timely manner.

PROCEDURE:
General Requirements

1. A member, or authorized representative acting on the member's behalf, may file a grievance. For purposes of this policy, a provider is an authorized representative when acting on the member's behalf with the member's written consent. Grievances expressing dissatisfaction with an "Adverse Benefit Determination" shall not be treated as grievances but may be appealed as described in Title XIX/XXI Notice and Appeal Requirements and Notice and Appeals Requirements SMI and Non-SMI/Non-Title XIX/XXI.
2. There are no time limits for filing a member grievance. The Health Plan is responsible for processing grievances pursuant to the requirements described within this policy. The processing of grievances is not delegated by the Health Plan.
3. Grievances may be filed orally or in writing. Grievances received orally shall be reduced to writing by Grievance and Appeals Department staff.
4. The Health Plan furnishes Grievance and Appeal System information to enrollees no later than 12 days after the Health Plan receives notice of the enrollment and annually thereafter. Additionally, the Health Plan provides written notification of any significant change in this policy at least 30 days before the intended effective date of the change.
5. The Grievance and Appeals Department maintains a record/log of all grievances. At a minimum, the log will include:

a. A general description of the reason for the grievance
b. The date of receipt
c. The date and description of each review and the resolution
d. Any actions taken, including the member's previous grievance history and follow-up activities associated with the grievance
e. The name and ID number of the member for whom the grievance was filed
f. The name of the individual filing the grievance on behalf of the member, if applicable
g. The member's eligibility type and relevant demographics (e.g., Title XIX/XXI, Non-Title XIX/XXI, Seriously Mentally Ill (SMI), General Mental Health (GMH), Substance Abuse (SA), Child/Adult, Children's Rehabilitative Services (CRS), etc.

6. Health Plan staff thoroughly investigate grievances using the applicable statutory, regulatory, contractual and policy provisions, ensuring that relevant facts are obtained from all parties.
7. Health Plan staff with the appropriate clinical expertise are required to make all decisions on grievances involving clinical issues. These staff cannot have been involved in any previous review or decision-making regarding the grievance.
8. Health Plan staff and its network providers do not to engage in conduct to prohibit, discourage or interfere with a member's or a provider's right to assert a member grievance, appeal, or claim dispute or use any Grievance and Appeal System process. Health Plan staff and its network provider staff are prohibited from retaliating against any person for filing a grievance.
9. Health Plan staff provide reasonable assistance to members in completing forms and taking other procedural steps necessary to file a grievance or an appeal. The written information provided to members describing the Grievance and Appeal System including the grievance process, the appeals process, enrollee rights, the Grievance and Appeal System requirements and timeframes, are available in each prevalent non-English language spoken in the Health Plans service area and in an easily understood language and format. The written documents are also available in alternative formats upon request at no cost. Auxiliary aids and services are available upon request and at no cost. The written materials include taglines in the

prevalent non-English languages in Arizona and in large print (conspicuously visible font size) explaining the availability of written translation or oral interpretation services and include the Health Plan's toll free and TTY/TDY telephone numbers for customer service. The Health Plan does not substitute oral interpretation services for written translation of vital materials. The Health Plan informs members that oral interpretation services are available in any language, and alternative communication formats are available for members who are deaf or hard of hearing or are blind or have low vision. Grievances are to be filed with the Health Plan. Health Plan staff do not require or encourage members to file grievances with the Arizona Healthcare Cost Containment System (AHCCCS).

10. The Health Plan is responsible for responding to requests from the AHCCCS Clinical Issue Resolution Unit involving member complaints, concerns, and issues brought to AHCCCS' attention by AHCCCS members, family members, providers, and other concerned parties. Upon request, the Health Plan shall provide the Clinical Resolution Unit with a written summary that describes the steps taken to resolve the issue, including findings, the resolution, and if indicated, a need for corrections. The Health Plan shall acknowledge receipt of an issue referral expeditiously and according to the urgency and response timeframe identified by the AHCCCS/DHCM Clinical Resolution Unit as specified in Section F, Attachment F3, Contractor Chart of Deliverables and ranging from 2 to 72 hours as indicated by the complaint urgency
11. Grievances are expeditiously reviewed upon receipt to determine if the issues are most appropriately resolved pursuant to Quality of Care Concerns, Grievance Investigations, Title XIX/XXI Notice and Appeal Requirements, or Notice and Appeals Requirements SMI and Non-SMI/Non-Title XIX/XXI. If the issue is most appropriately resolved by another process, the issue is immediately referred to the appropriate department.
    a. Health Plan staff ensure they immediately take whatever action may be reasonable to protect the health, safety and security of any client, witness, individual filing the grievance, or individual on whose behalf the grievance is filed.
    b. Notice is given to a public official, law enforcement office, or other person, as required by law, that an incident involving death, abuse, neglect or threat to a person receiving services has occurred, or that a dangerous condition or event exists.

12. Health Plan staff notify the Arizona Health Care Cost Containment System (AHCCCS) when:
    a. A person receiving services files a grievance with law enforcement alleging criminal conduct against an employee;
    b. An employee or contracted staff files a grievance with law enforcement alleging criminal conduct against a person receiving services;
    c. An employee, contracted staff, or person receiving services is charged or convicted of a crime related to a rights violation, physical or sexual abuse, or death of a person receiving services.
13. The Health Plan provides proactive care coordination for members who frequently contact AHCCCS, State and local officials, the Governor's Office and/or the media and for those who have multiple grievances regarding services or the AHCCCS Program.
14. Grievances are resolved in writing . Grievances are resolved within 10 business days of receipt absent extraordinary circumstances and always as expeditiously as the member's health condition requires. However, in no event may the timeframe for resolution exceed 90 days from the date of receipt.
15. Health Plan staff resolve member grievances in a manner that holds subcontractors and providers accountable for actions that precipitated or caused the member grievance.

Grievance Process

1. Upon receipt of a grievance, regardless of the source, it is entered into the member relations documentation system by the Grievance Coordinator.

Acknowledgement of Grievance

1. Grievances are acknowledged verbally or in writing based on the member's (or other person's) preference. The grievance is acknowledged as quickly as the member's health condition requires but in no event more than 5 business days after the date of receipt.
2. If applicable, a copy of the written acknowledgement letter is attached to the member's file in the member relations documentation system.

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Investigation of Grievance

1. The Grievance Coordinator researches and gathers supporting documentation regarding the grievance. This may include contacting the member for additional information, requesting information from a provider's office, researching the member's claims history, or reviewing the member's care plan activity. The Health Plan considers information sent by members or their authorized representatives when making grievance determinations.

2. Any grievance related to a medical necessity decision is routed to a Medical Director for review and resolution.

Grievance Resolution and Notification

1. Grievances are resolved in a timely manner that is appropriate for the complexity of the grievance and the member's health condition.

2. Grievances are resolved as soon as possible and absent extraordinary circumstances, no later than ten (10) business days from the date of receipt. In no event should the resolution and notification to the member exceed ninety (90) days. If the Health Plan fails to meet the required decision and notification timeframes for grievances, the Health Plan allows members to initiate a State Fair Hearing.

3. Clinically urgent grievances are resolved as expeditiously as possible and no later than seventy-two (72) hours after receipt.

4. The Grievance Coordinator documents the resolution in the member relations documentation system.

5. The Grievance Coordinator reviews the findings with an individual qualified/certified at the appropriate level to provide a resolution.

6. The Grievance Coordinator notifies the grievant of the resolution, in writing, as soon as possible after the resolution determination.

    a. The notice of resolution includes the results of the resolution process and the date it was completed. The grievance notification is provided in a format that is easy to understand, readily accessible, and consistent with State and Federal requirements. All grievance notifications sent to existing and

potential members contain instructions for requesting and accessing auxiliary aids and services, are available in alternative formats upon request and free of charge, are available in the prevalent non-English languages in the service area,and contain taglines in the prevalent non-English languages in the state.

b. If the grievant is not the member or prospective member, legal guardian, or authorized representative, no Protected Health Information is included in the resolution unless a release of information is on file.

c. In the event the grievant is dissatisfied with the resolution of the grievance, the issue(s) in dispute may still be referred to the applicable appeal and grievance processes; however the Health Plan's grievance decision cannot be appealed. For allegations of rights violations concerning persons determined to have SMI, see Policy titled Grievance Investigations.

d. The Grievance Coordinator ensures all AHCCCS-required data elements have been collected for tracking, trending, and reporting of grievances.

e. A copy of the member-specific resolution letter is attached to the member's file in the member relations documentation system.

Allegations of Discrimination

1. It is the policy of the Health Plan not to discriminate on the basis of race, color, national origin, sex, age or disability. Grievances alleging an act of discrimination in any health program or activity administered by the Health Plan or any act prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. § 18116) are investigated pursuant to this policy. The following specific requirements apply to allegations of discrimination covered by Section 1557:

    a. The Grievance System Administrator is the Section 1557 Coordinator and is charged with ensuring compliance with Section 1557.

    b. Grievances alleging an act prohibited by Section 1557 may be received orally or in writing. Grievances received orally shall be reduced to writing by Grievance and Appeals Department staff and forwarded for initial review to the Section 1557 Coordinator.

c. Grievances must be received within 60 days of the date the grievant becomes aware of the alleged discriminatory act.

d. Upon request, the Section 1557 Coordinator shall provide, upon request, copies of Section 1557 and its implement regulations.

e. The grievant shall be afforded an opportunity to present allegations and evidence, including the opportunity for an in-person interview with the Section 1557 Coordinator or Designee.

f. The Section 1557 Coordinator shall issue a written resolution to the grievant with sufficient detail to demonstrate a complete and thorough investigation was completed, subject to CC.COMP.04 Confidentiality and Release of Protected Health Information and shall apply the preponderance of evidence standard.

    i. The written resolution shall inform the grievant of the right to appeal the decision to the Chief Executive Officer or Designee within 15 days of receipt of the written resolution.

        1. The Chief Executive Officer or Designee shall issue a written, final resolution no more than 30 days after receipt of the request for review.

    ii. The written resolution issued by the Section 1557 Coordinator shall also inform the grievant that the decision does not prohibit the grievant from pursuing other administrative or legal remedies.

g. All files and documentations related to an investigation conducted pursuant to Section 1557 shall be kept confidential and not disclosed for an unauthorized purpose.

Tracking and Reporting of Grievances

1. Grievance data is tracked, trended, and analyzed by the Quality Improvement Committee, or a Quality Improvement Subcommittee no less frequently than quarterly.
2. The Grievance System Administrator prepares and submits monthly and quarterly grievance system reports as defined by contract.

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REFERENCES:
42 C.F.R. 438.408 – Resolution and notification: Grievances and appeals.
Arizona Administrative Code (A.A.C.) Title 9, Chapter 34 (Arizona Health Care Cost Containment System Grievance System)
42 U.S.C. § 18116
Grievance Investigations
Title XIX/XXI Notice and Appeal Requirements
Notice and Appeal Requirements SMI and Non-SMI/Non-Title XIX/XXI
Quality of Care Concerns
Confidentiality and Release of Protected Health Information

DEFINITIONS:
AHCCCS means the Arizona Health Care Cost Containment System
Grievance means a member's expression of dissatisfaction about any aspect of their care other than an adverse benefit determination. Grievances include, but are not limited to, concerns about the quality of care or services provided, a disagreement with a decision to extend the timeframe for making an authorization decision, aspects of interpersonal relationships with service providers, and lack of respect for members' rights.

Adverse Benefit Determination means

- The denial or limited authorization of a requested service including the type and level of service;
- The reduction, suspension or termination of a previously authorized service;
- The denial, in whole or part, of payment for service;
- The failure to provide services in a timely manner;
- The failure to act within established timeframes for resolving an appeal or complaint and providing notice to affected parties; and
- For a Title XIX or XXI person in a rural area, the denial of the Title XIX or XXI person's request to obtain services outside the network.

REVISION LOG

REVISION	DATE
Added Section 4.d. under Procedure providing for additional processes to resolve a complaint; added definitions for ADHS/DBHS, AHCCCS, HUM and URAC; updated references and added hyperlinks; and added URAC reference.	01/07/2016

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Updated all sections to reflect the migration from DBHS to AHCCCS.	11/16/2016
Throughout policy, word “grievance” is used in lieu of “complaint” to align policy with AHCCCS policies and procedures, AHCCCS Contract, the Administrative Code, and Code of Federal Regulations; Added Section A(2) describing the assistance Cenpatico provides to members in completing procedural steps necessary to file a grievance or appeal; Added additional language in A(4) related to prohibition against retaliation; Clarified language regarding acknowledgement being issued as expeditiously as the member’s condition requires; Added 10-day standard for resolution of grievances that must be met absent “extraordinary” circumstances; Added section A(8) regarding holding providers accountable through the grievance and appeal process. Added section A(9) to comply with AMPM 960 related to screening of Quality of Care Concerns for resolution under a Grievance and Appeal Process, Grievance/Complaint Process, or Quality Management Process. Added language to require timely reporting to law enforcement or other regulatory bodies when a member safety issue or dangerousness issue comes to Cenpatico’s attention. Updated provision regarding timely reporting of certain matters to AHCCCS as required by AMPM 960 and A.A.C. Title 9, Chapters 21 and 34 Created a timeframe for screening Grievances that may require referral to another area.	03/06/2017
Added language to policy providing for investigations pursuant to Section 1557 of the Affordable Care Act.	04/03/2017
Updated Scope to apply to all Arizona Medicaid plans; Clarified that a grievance must be filed by a member or a member’s “authorized representative”; Added to policy that members are notified upon enrollment of the member grievance policy; Added details regarding the grievance log maintained by the health plans; Rearranged several sections in the general requirements section and procedure section to add clarity; Add details regarding grievance investigation process;	05/14/2018

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Added details regarding reporting requirements, including reporting based on CRS designation.	
Annual Review Added details regarding the management of high frequency callers and those who contact government entities. Added details regarding the role of Health plan staff in the filing of grievances with AHCCCS.	03/26/2019
Added language to clarify that the grievance process is not delegated to providers. Added language that grievances can be filed orally or in writing and grievance decisions cannot be appealed. Added language to clarify time lines for the filing of grievances.	01/21/2020
Updated language to clarify the scope of the health plan's assistance with the filing of grievances and appeals.	08/07/2020
Updated the frequency at which written information is provided to members regarding the Grievance and Appeal system. Updated the required information contained in each grievance record.	08/13/2020
Updated resolution turnaround times to align with contract requirements	09/14/2020
Added details regarding the Health Plan's response requirements to inquiries from the AHCCCS Clinical Issue Resolution Unit.	02/18/2021
Annual Review. Added language to ensure the application of all pertinent rules to the grievance investigation process.	09/20/2021
Removed CMDP from populations covered. Updated reporting and tracking requirements.	04/18/2022
Updated required elements for grievance log. Clarified health plan's role in providing assistance to members. Clarified circumstances that warrant a State Fair Hearing. Added details regarding information considered in grievance investigations. Updated details on the required format of grievances notifications.	11/21/2022
Updated member notification requirements. Clarified the requirements for written and oral communications, including the availability of health plan assistance with filing grievances.	05/23/2023
Updated grievance resolution written requirement verbiage.	10/17/23

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POLICY AND PROCEDURE APPROVAL

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