

# POLICY AND PROCEDURE

<b>POLICY NAME:</b> HIM Grievance System	<b>POLICY ID:</b> HIM.IN.AG.01
<b>BUSINESS UNIT:</b> Managed Health Services - IN	<b>FUNCTIONAL AREA:</b> Appeals and Grievance
<b>EFFECTIVE DATE:</b> 7/26/2018	<b>PRODUCT(S):</b> Marketplace (On Exchange and Off Exchange)
<b>REVIEWED/REVISED DATE:</b> 3/2019; 5/2019; 9/2019; 3/2020; 5/2020; 05/2021; 09/2021; 09/2022; 02/2025, 03/2025, 04/2025	
<b>REGULATOR MOST RECENT APPROVAL DATE(S):</b> N/A	

## POLICY STATEMENT:

All Areas and Departments within Centene Corporation and its subsidiaries (collectively, "Centene" or the "Company") must have written Policies and Procedures that address core business processes related to, among other things, compliance with laws and regulations, accreditation standards and/or contractual requirements.

## PURPOSE:

To offer a thorough and consistent process for members to express dissatisfaction to the health plan. The process will include acknowledgement, tracking, investigation and timely resolution as well as the opportunity for the member to appeal the resolution if they are not satisfied with the MHS response.

This policy and procedure applies to Ambetter/Marketplace line of business.

## SCOPE:

This policy applies to Managed Health Services (MHS) Compliance, Quality Improvement and Member Service Departments. This policy and procedure applies to the Marketplace line of business, both On and Off Exchange plans.

## DEFINITIONS:

**Complaint:** A complaint is defined as any expression of dissatisfaction expressed to the insurer by the claimant, or a claimant's authorized representative, about an insurer or its providers with whom the insurer has a direct or indirect contract.

**Grievance:** A grievance is defined as an expression of dissatisfaction about any matter other than an action. Possible 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. The term is also used to refer to the overall system that includes grievances and appeals handled at the Plan level.

**Appeal:** A request for a Plan to reconsider a previous decision including an action.

**Action:** The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure of the health plan to provide services in a timely manner as defined in the appointment standards described herein; or the failure of the health plan to act within timeframes for the health plan's prior authorization review process specified herein.

## POLICY:

MHS will establish and maintain a procedure for the receipt and prompt internal resolution of all complaints and grievances that complies with all applicable state and federal laws.

Members or their authorized representative may file a grievance orally, or in writing. A health care practitioner or provider acting on behalf of the member may file a grievance.

## Grievances

A *grievance* is defined, in accordance with IN Code § 27-13-10-7, as any dissatisfaction expressed by or on behalf of a covered individual regarding:

- a determination that a service or proposed service is not appropriate or medically necessary;
- a determination that a service or proposed service is experimental or investigational;
- the availability of participating providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between:
  - a covered individual and an insurer; or
  - a group policyholder and an insurer; or

- an insurer’s decision to rescind an accident and sickness insurance policy; and for which the covered individual has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

Any other matters that pertain to the delivery of health care, such as dissatisfaction with the quality of care or services received, provider, provider staff, or health plan staff conduct (such as rudeness) or the failure to respect an enrollee’s rights should be considered a grievance regardless of the timeframe for resolution, per the terms of regulations at Title 42 CFR 438, Subpart F.

If the matter requires MHS to review the situation and supply a decision, the grievance will include appeal rights if the subsequent decision is an adverse determination. ***For appeals related to denial of medical necessity or benefit limitations please refer to policy IFP.UM.08 – Appeal of Adverse UM and Benefit Determinations.***

MHS will not take action against a member or provider solely on the basis that a grievance or appeal was filed.

**PROCEDURE:**

**A. Member Notification of Grievance Process**

1. Members are notified of the MHS Grievance Process in the Member Handbook, on the Ambetter MHS Member Website, at least annually in the Member Newsletter and in any notice of action to members. The notification includes the toll-free number and address at which a grievance or appeal of a grievance may be filed.
2. Ambetter MHS requires its Provider Network to post a description of the Members rights to file a grievance. The posting must be in a conspicuous public location in each facility that offers services on behalf of MHS.

**B. Grievance Filing Timeframes**

Grievance Step	Filing Timeframe
Step 1 – Grievance (dissatisfaction)	180 calendar days from the date of the event
Step 2 – Appeal of a Grievance	120 calendar days from receipt of the original determination (includes expedited)

*For complaints unable to be resolved during the grievance and appeal of a grievance process, members may seek assistance from the governmental agency that regulates insurance at the following:*

*State of Indiana Department of Insurance  
 Consumer Services Division  
 311 West Washington Street, Suite 300  
 Indianapolis, IN 46204  
 Consumer Hotline: (800) 622-4461; (317) 232-2385  
 Complaints can be filed electronically at [www.in.gov/idoi](http://www.in.gov/idoi).*

**C. Filing a Grievance**

1. The member, member’s authorized representative or provider may file a grievance in-person, orally or in writing. A grievance will be acknowledged in writing within 3 (three) calendar days of receipt of the grievance.
2. The Plan gives members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services/bilingual staff, and toll-free numbers that have adequate TTY/TTD and interpreter capability. Refer to IN.MBRS.12.
3. An oral grievance is generally received by a Member Service Representative (MSR) by telephone within 180 calendar days of the situation the member is dissatisfied with. All inquiries received by MSRs are probed to validate the possibility of any inquiry actually being a grievance or appeal.
4. The MSR opens a case in the customer interaction documentation system and documents the substance of the complaint (expression of dissatisfaction received by a member that will be resolved by the close of the next business day from receipt) as provided by the member or the member’s authorized representative.
5. The MSR may attempt to resolve the complaint at the time of the call and/or transfer the call. If the MSR resolves the complaint during the call (first call resolution), the case is resolved and marked as complete in customer interaction documentation system. No acknowledgement letter is required.

6. If the complaint is not resolved during the call, the MSR documents the substance of the grievance and any actions taken in the customer interaction documentation system and routes the grievance to the Grievance & Appeals Department.
7. Acknowledgement of an oral grievance, not resolved during the call, is sent in writing by the responsible Grievance Coordinator (GC) within 3 (three) calendar days of receipt of the grievance.
  - a. Written correspondence regarding grievances is received in the mailroom, date stamped and forwarded to the Grievance & Appeals Department the same business day.
8. The GC documents the receipt and a description of the grievance and the date of acknowledgement in the tracking system.
  - a. A record of each grievance received will be maintained in accordance with 760 IAC 1-59-5 on the Grievance Tracker Database and within the customer interaction documentation system.
  - b. The grievance will be aggregated into the following categories in accordance with NCQA Standards:
    - i. Quality of Care
    - ii. Access
    - iii. Attitude and Service (includes Delegated Vendor Service)
    - iv. Billing and Financial Issues
    - v. Quality of Practitioner Office Sites

#### D. Investigation/Research

1. The GC will research and gather supporting documentation regarding the grievance. This may include contacting the member for additional information, requesting information from the provider office, researching the member's claims history or reviewing the member's care plan activity.
  - a. **Crisis Calls** - The GC will conference, and will not transfer, the member with Envolv People Care at x6101949 for crisis call handling in accordance with **EPC.AZCL.WI.07.01** Crisis Assessment and Crisis Resolution Process.
  - b. **Reference the EPC Crisis Line documentation found on the MHS Source of Truth** for Crisis Call handling. The GC will retain the most updated version of the **EPC Crisis Line** documentation.
2. The GC may send the grievance to another department such as but not limited to Provider Relations or the Billing & Enrollment team for further investigation, as appropriate.
3. If the GC receives a grievance that could be a quality-of-care issue, the grievance case is routed to the QI Coordinator for investigation. Reference policy CC.QI.17.

#### E. Resolution Time Frames

Grievance Step	Resolution Timeframe
Step 1 – Grievance	Not to exceed 20 business days, from receipt of the request <i>(An additional 10 business days can be requested if needed)</i>
Expedited Grievances <i>(Clinically urgent grievances)</i>	48 hours of receipt of the request <i>(2 calendar days)</i>
Step 2 – Appeal of a Grievance <i>(Excluding medical necessity decisions)</i>	45 calendar days from receipt of the appeal request

#### F. Resolution of Grievance (EXCLUDES MEDICAL NECESSITY DECISIONS)

1. Grievances, *unrelated to medical necessity decisions and benefit limitations*, received at MHS are investigated and resolved by the GC. Applicable grievances related to Quality of Care or Quality Physician Office Sites are routed to the Quality Improvement department for investigation. Refer to policy CC.QI.17 Potential Quality of Care Incidents>Quality Issues Review.
2. Grievances will be resolved as expeditiously as possible but not more than 20 business days from the date of receipt of the request.
  - a. MHS may extend the timeframe for disposition of a standard grievance for up to *10 business days* if the member requests the extension or the Plan demonstrates that there is need for additional information and how the delay is in the member's interest. If MHS extends the timeframe, it shall,

- for any extension not requested by the member, give the member written notice of the reason for the delay.
- b. The time period may be extended for the additional 10 business days if we provide the member and the member's authorized representative, if applicable, written notification of the following within the first 20 business days:
  - i. That *we* have not resolved the *grievance*;
  - ii. When *our* resolution of the *grievance* may be expected;
  - iii. The reason why the additional time is needed.
- c. The decision regarding the grievance will then be made within 10 business days after the date of the 20 business day time frame expiration.
- 3. The substance of the grievance, any actions taken, and the resolution will be documented in customer interaction documentation system.
- 4. Expedited grievances must be resolved as expeditiously as possible not to exceed 48 hours from receipt of the request.
  - a. Due to the 48-hour resolution timeframe, the standard requirements for notification and acknowledgement do not apply to expedited grievances, however, MHS will make a reasonable effort to notify the member orally to acknowledge receipt of the expedited grievance.
  - b. If the request for an expedited grievance is denied by MHS because it does not meet the criteria for an expedited review, MHS will transfer the grievance to the standard grievance timeframe, make a reasonable effort to notify the member orally of the denial for an expedited review and follow-up with written notice of such within (2) calendar days.
- 5. The member will be notified in writing of the disposition of the grievance or expedited grievance within (5) business days of the resolution determination date.
  - a. MHS will make a reasonable effort to provide oral notification to the member of the resolution of an expedited grievance followed by written notice.
  - b. The notice will include the resolution of the issue (to the extent that it can be shared), the member's right to appeal the grievance resolution and instructions on how to make that appeal.
  - c. In some instances, MHS may not be able to inform members of the final disposition. In these cases and in all cases related to quality of care, MHS will, at a minimum, send notification that the complaint was received and investigated. The letter will acknowledge receipt of the concern and indicate that the concern was forwarded to the Quality Improvement department for full investigation and corrective action as indicated and that the incident will be tracked for future occurrence.

#### **G. Filing an Appeal of a Grievance [Second Level Grievance]**

- 1. If a member is not satisfied with the outcome of the grievance, the member or their authorized representative can file an Appeal to the decision of the Grievance within 120 calendar days from receipt of the original determination (includes expedited). The instructions and address to submit the appeal is communicated in the closure letter.
- 2. Assistance with the filing process is available and includes form completion, interpreter services, and toll-free phone numbers with TTY/TTD capacity. Reference policy IN.MBRS.12.
- 3. Upon receipt of an appeal of a grievance, the MHS Member Services Representative will review the substance to clearly identify the nature of the concern and the action requested by the member.
- 4. The responsible Member Service Representative will thoroughly research and document the information related to the appeal to facilitate resolution including but not limited to the previous grievance history of information.
- 5. The Member Services Representative will open an appeal of a grievance case; document the substance of the grievance and any actions taken in the customer interaction documentation system and route to the Grievance & Appeals Department.
- 6. The responsible Grievance Coordinator (GC) will send written acknowledgement of the appeal within three (3) business days.
  - i. The GC will verify the members' preferred language and/or communication format in the OMNI system by accessing the *Alternate Format Preference/Preferred Written/Preferred Spoken Language fields*. Translation of notifications will be sent to the following sources:
    - a. Language translation and Large Print requests go to Indy Communications ([Communications@mhsindiana.com](mailto:Communications@mhsindiana.com))
    - b. Braille translation requests go to MHS Customer Satisfaction Team ([CST@mhsindiana.com](mailto:CST@mhsindiana.com))
  - ii. A record of each grievance received will be maintained in accordance with 760 IAC 1-59-5.
  - iii. The record will be aggregated into the following categories in accordance with NCQA Standards:
    - a. Quality of Care

- b. Access
- c. Attitude and Service (includes Delegated Vendor Service)
- d. Billing and Financial Issues
- e. Quality of Practitioner Office Sites

**H. Investigation/Research of the Appeal of a Grievance**

1. The GC will research and gather supporting documentation regarding the appeal. This may include contacting the member for additional information, requesting information from the provider office, researching the member's claims history or reviewing the member's care plan activity.
  - a. **Crisis Calls** - The GC will conference, and will not transfer, the member with Envolve People Care at x6101949 for crisis call handling in accordance with **EPC.AZCL.WI.07.01** Crisis Assessment and Crisis Resolution Process.
  - b. **Reference the EPC Crisis Line documentation found on the MHS Source of Truth** for Crisis Call handling. The GC will retain the most updated version of the **EPC Crisis Line** documentation.
2. The GC may send the appealed grievance to another department such as but not limited to Provider Relations or the Billing & Enrollment team for further investigation, as appropriate.
3. If the GC receives an appeal of a grievance that could be a quality-of-care issue, the case is routed to the QI Coordinator for investigation. Reference policy CC.QI.17.

**I. Resolution of Appeal of a Grievance [2<sup>nd</sup> Level Grievance] (EXCLUDES MEDICAL NECESSITY DECISIONS)**

1. An Appeal of a Grievance must be resolved within 45 calendar days [per IN Code § 27-13-10-8 **Appeal of grievance decisions**] of receipt of the request.
2. If MHS is unable to resolve the appeal within 45 calendar days because of circumstances beyond its control, the member is notified in writing that it requires more time to complete the process on or before the end of the 45-calendar day-time frame.
3. The member will be notified in writing of the disposition of the appeal of a grievance within (5) business days of the resolution determination date.
  - a. The written resolution letter will include the decision reached, the reasons, policies and procedures that are the basis of the decision, notice of the member's right to further remedies allowed by law and the department, address and telephone number through which the member may contact a qualified representative to obtain more information.
4. If a member is not satisfied with the outcome of the Appeal of the Grievance, or have a complaint that they have been unable to resolve with MHS, they have the option of seeking the assistance of the Indiana Department of Insurance (IDOI) by mail, telephone or email:

**State of Indiana Department of Insurance**  
 Consumer Services Department  
 311 West Washington Street, Suite 300  
 Indianapolis, Indiana 46204  
 Consumer Hotline: (800) 622-4461; (317) 232-2395  
 Complaints can be filed electronically at [www.in.gov/idoi](http://www.in.gov/idoi).

**REFERENCES:**

IN Code § 27-13-10-7 Resolution of grievances  
 IN Code § 27-13-10-8 Appeals of grievance decisions  
 760 IAC 1-59-14  
 IFP.UM.08 Appeal of Adverse UM and Benefit Determinations  
 CC.QI.17 Potential Quality of Care Incidents  
 IN.MBRS.08 Member Inquiry Policy  
 EPC.AZCL.WI.07.01 Crisis Assessment and Crisis Resolution Process  
 EPC Crisis Line  
 IN.MBRS.12 Oral Interpretation Services

**ATTACHMENTS:**

IFP.UM.08 Appeal of Adverse UM and Benefit Determinations  
 CC.QI.17 Potential Quality of Care Incidents

IN.MBRS.08 Member Inquiry Policy  
 EPC.AZCL.WI.07.01 Crisis Assessment and Crisis Resolution Process  
EPC Crisis Line  
 IN.MBRS.12 Oral Interpretation Services

**ROLES & RESPONSIBILITIES:** Senior Manager or Project Coordinator II, Grievance & Appeals

**REGULATORY REPORTING REQUIREMENTS:** N/A

**REVISION LOG**

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Ad Hoc Review	<p>Section B. Grievance Filing Timeframes “updated Appeal of a Grievance filing timeframe from 180 to 60 calendar days            Made grammatical corrections throughout policy            Section C. Filing a Grievance, added the definition of a complaint            Changed “grievance” to “complaint” where applicable in section C.            Section C.#8.b; iii. Added “includes Delegated Vendor Service)”            Updated 20 business days to 30 calendar days for Resolution timeframe for Appeal of a Grievance and throughout policy where applicable            Added Section G. Filing an Appeal of a Grievance with steps that outline process            Added Section H. Investigation/Research of the Appeal of a Grievance with steps that outline process            Added to Section I.#2.b. “the member will be notified of the reason for the delay”            Added to Section I.#4 the next level of Appeal after the decisions of the Appeal of a Grievance</p>	3/2019
Ad Hoc Review	<p>Corrected grammatical errors throughout the policy            Added “from the matter that is the subject of the grievance” to section C. Filing a Grievance #1            Added the definition of complaints “expression of dissatisfaction received by a member that will be resolved by the close of the next business day from receipt” section C. Filing a Grievance #3            Added “includes Delegated Vendor Service” to section C. Filing a Grievance #7 iii. Attitude and Service            Added section G. Filing an Appeal of a Grievance #1-#6 outlining the steps to file an Appeal of a Grievance            Added section H. Investigation/Research of the Appeal of a Grievance #1-#3            Added #4 “if a member is not satisfied with the outcome of the Appeal of the Grievance, they have the option to file a State Fair Hearing and included the address, phone, fax info</p>	05/2019
Ad Hoc Review	<p>Updated Section C. Filing a Grievance; moved #1 to #6 to improve the flow of the process from a complaint to a grievance.            Added the steps to resolve a QOC grievance and the steps to process clinically involved grievances.            Added to Section B. Filing Timeframes, “If members are not satisfied with the outcome of their grievance</p>	09/2019

	<p>and/or appeal of a grievance, the member may seek assistance from the governmental agency that regulates insurance at the following:  State of Indiana Department of Insurance  Consumer Services Division  311 West Washington Street, Suite 300  Indianapolis, IN 46204  Consumer Hotline: (800) 622-4461; (317) 232-2385  Complaints can be filed electronically at <a href="http://www.in.gov/idoj">www.in.gov/idoj</a>.”</p> <p>Updated Section C; moved #1 to #6 to improve the flow of the process from a complaint to a grievance. Added the steps to resolve a QOC grievance and the steps to process clinically involved grievances.</p>	
Ad Hoc Review	<p>Deleted Arbitration reference to filing timeframe from “Grievance Filing Timeframes” grid  Rearranged DOI filing information and Reference to HIM.UM.08[IFP.UM.08] Appeals for UM Decisions instructions for flow  Updated turnaround times for filing a grievance and filing an appeal of a grievance throughout policy  Updated the reference to the IN.QI.18 policy to CC.QI.17 throughout policy.</p>	03/2020
Ad Hoc Review	<p>Updated Step 1 – Grievance Expedited Grievances (Clinically urgent grievances) (An additional 10 from “calendar” to business days  Updated Step 2 – Appeal of a Grievance (Excluding medical necessity decisions) (An additional 10 from “calendar” to business days may be requested if needed)  Corrected Appeals of a grievance filing timeframe on page 8 from 30 calendar days to 60 calendar days  Corrected the revision log to add 2019 revisions</p>	05/2020
Yearly Review	<p>Updated Grievance Timeframes per 2021 Ambetter EOC:  Appeal of a Grievance  [or 2<sup>nd</sup> Lvl Grievance]  Expedited Grievances  Appeal of a Grievance-  Resolution Timeframe</p>	05/2021
Ad Hoc	<p>Moved to the new Archer policy template, added the Policy Statement and updated the Functional area to Appeals and Grievance.</p>	09/2021
Ad Hoc	<p>Added the Alternative Language and Alternate Format process:  i. The GC will verify the members’ preferred language and/or communication format in the OMNI system by accessing the Alternate Format Preference/Preferred Written/Preferred Spoken Language fields. Translation of notifications will be sent to the following sources:  (a) Language translation requests go to Indy Communications (<a href="mailto:Communications@mhsindiana.com">Communications@mhsindiana.com</a>)  (b) Braille translation requests go to MHS Customer Satisfaction Team (<a href="mailto:CST@mhsindiana.com">CST@mhsindiana.com</a>)  a.b. A record of each grievance received will be maintained in accordance with 760 IAC 1-59-5.</p>	9/2021
Annual Review	<p>Removing all references to the Crisis Call Policy (IN.MBRS.10) —since the call center archived the process.</p>	09/2022

	<p>Updated all references to HIM.UM.08 to new naming IFP.UM.08.</p> <p>Changed the ACK letter for an Appeal to a Grievance to 5 business days from 3. Added <i>and Large Print</i> to the location where members may request alternative materials.</p> <p>Added the name to the following referenced policy, CC.QI.17 Potential Quality of Care Incidents.</p> <p>Referenced the Case Management process for Crisis Calls <b>EPC.AZCL.WI.07.01</b> Crisis Assessment and Crisis Resolution.</p> <p>Added <b>EPC Crisis Line</b> documentation to all Crisis Call references and linked to references section.</p> <p>Embedded all referenced docs to Attachments section.</p>	
Ad Hoc	Updated Step 2, Page 3 from 120 calendar days to 45 calendar days and removed the statement regarding 10 additional days can be requested to complete the review.	02/2025
Ad Hoc	<p>Replaced IC 27-8-28-6 "Grievance"</p> <p>IC 27-8-28-17 "Appeal of a Grievance"</p> <p>with IN Code § 27-13-10-7 Resolution of grievances</p> <p>IN Code § 27-13-10-8 Appeals of grievance decisions</p> <p>Replaced 5-day TAT for grievance acknowledgment letter with 3-day TAT</p> <p>Updated page 3 F a to business days from calendar days.</p>	03/2025
Ad Hoc	Added applicability for On and Off Exchange	4/2025

### POLICY AND PROCEDURE APPROVAL

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