



Policy and Procedure No: RM 107.4	Revision No: 4
Division: Care Management	
Department: Risk Management	
Title: PHP Member Grievance Process	
Effective Date: 1/1/2006	
Supersedes Policy No: AG 1.0, 95003, RM 1.4, RM107.0, RM 107.1, RM 107.2, RM 107.3	
Reviewed/Revised by: Tiffany Smith	Review/Revision Date: 12/3/2025
Approving Committee: Risk Management Committee	Date: 12/11/2025
Executive Oversight Committee Date: 12/16/2025	

Purpose:

The purpose of this policy is to define the PHP process for receiving, documenting, investigating, resolving, and reporting Medicare enrollee grievances. This includes grievances related to, but not limited to, enrollment and disenrollment, benefit packages, access to care, marketing practices, customer service, organization determinations and reconsiderations, coverage determinations and redeterminations, quality of care, grievances related to CMS-identified issues, and any other expressions of dissatisfaction with PHP services, operations, or delegated entities.

Policy:

It is the policy of PHP to:

1. Identify and process grievances through appropriate internal policies and procedures.
2. Expeditiously notify members of decisions, but no more than thirty (30) days after the receipt of the grievance. If the member requests an extension, or if there is a justified need for information and documentation in which a delay is in the best interest of the member, PHP may extend the thirty (30) day timeframe up to an additional fourteen (14) days after immediately notifying the member in writing of the reasons for the delay.
3. Notify members of decisions to expedited grievances within twenty-four (24) hours. When written notification is required for expedited grievances, plans may initially provide verbal notification of its decision and must deliver written confirmation of its decision within three (3) calendar days of the verbal notification.
4. Inform the member of the disposition of their grievance and inform them of their right to file written complaints to the appropriate bodies.
5. Respond to all grievances in writing. If the member has specifically requested a no mail status, a preferred alternative method of delivery (i.e. email) will be requested. If the member declines, documents will be uploaded to the patient portal. If member is unable to access the patient portal, documents will be forwarded to the Primary Care Provider’s office, in a separate and sealed envelope, that is addressed to the member.

Procedure:

1. The Chief of Care Management has ultimate responsibility and oversight for the Medicare grievance system, including ensuring compliance with all applicable CMS regulations, internal

policies, and delegated entity requirements. This responsibility includes monitoring grievance intake, investigation, resolution, documentation, and reporting.

The Chief of Care Management is located at:

1710 La Brea Ave.
Los Angeles, CA 90046
Telephone number is: (323) 436-5000

- a. The Director of Care Coordination or designee, under the supervision of the Chief of Managed Care, is responsible for updating and maintaining the policies and procedures of the grievance system, as well as for continuously reviewing the operation of the grievance system to identify any emergent patterns of grievances.

1. Location of Files and Availability of and Assistance with Forms: The maintenance of grievance files is the ultimate responsibility of the Chief of Care Management. The central file for all PHP grievances is located at:

1710 La Brea Ave.
Los Angeles, CA 90046
Telephone number is: (323) 436-5000

- a. PHP will maintain copies of all grievance files, the responses to them, and logs recording them for a period of at least ten (10) years from the date filed. Examples of documents include: medical records, documents, evidence of coverage and other relevant information upon which PHP relied in reaching its decision.
- b. For members that request to file a grievance on the PHP grievance form, paper copies of PHP's grievance forms are available at all AHF Healthcare Centers and from PHP's Member Services (MS) Department.
 - i. Upon request, PHP will provide members with the grievance form and assistance with completing the form.
 - ii. MS can provide a copy of the grievance form, either email, fax or by mail.
 - iii. The form is available in Spanish and English.
- c. Cultural and Linguistic Requirements: All PHP staff shall ensure enrollees with limited English proficiency are able to communicate with plans regarding initial determinations, appeals, and grievances. Enrollees with limited English proficiency should have the same level of access to plan representatives and information regarding initial determinations, appeals, and grievances as enrollees who are proficient in English. Language line services are available to all PHP staff to assist in oral translations and staff also has access to written translation services.

2. Notifying Members of the grievance process: Members are advised of the grievance system at the time of initial enrollment via the Membership Services Guide presentation, involuntary disenrollment, annually, and upon request. The Health Plan must also notify enrollees about any changes to its grievance procedures thirty (30) days in advance of the effective date of the change.



- a. The Membership Services Guide is sent to each member within ten (10) days of enrollment and annually thereafter. The guide contains a description of the grievance process, including the following elements required by law:
 - i. An explanation of PHP's system for processing and resolving grievances, and how a member initiates a grievance.
 - ii. A statement that grievances may be filed in writing or verbally directly with PHP or at AHF Health Care Clinic.
 - iii. A statement that grievance forms are available from PHP's Member Services Department and in the office of each AHF Health Care Clinic.
 - iv. The local or toll-free telephone number a member may call to obtain information, request grievance forms, and file a verbal grievance.
 - v. The title, address, and telephone numbers of the PHP departments responsible for assisting in the completion of a request and processing and/or resolving grievances.
 - vi. The requirements and the timelines for PHP to acknowledge receipt of grievances, resolve grievances and notify the member of the resolution of grievances
- b. Members sign a Statement of Understanding acknowledging their understanding of the member grievance system. Additionally, members are advised annually of the grievance system in their annual MS Guide and at the time of receipt of any notice of action.

3. Initiating a Grievance

- a. A member or Appointment of Representative (AOR) may file a grievance up to sixty (60) calendar days following any incident or action that is the subject of his/her dissatisfaction. PHP may, but is not required to, accept and process a grievance that is filed after the sixty (60) day deadline. If PHP chooses not to accept untimely filing, PHP may dismiss the grievance.
- b. A member or AOR may file their grievance verbally by calling Member Services at 888-456-4175.
- c. A member or AOR may submit a written grievance twenty-four (24) hours a day, seven (7) days a week (including holidays) using the following methods:
 - i. Via email at PHP@positivehealthcare.org;
 - ii. Via the new electronic Grievance Submission Form located at <https://positivehealthcare.net/florida/php/for-members/complaint///>;
 - iii. Via Fax at 1-888-235-8552;
 - iv. Via US Postal mail at:

1710 La Brea Ave.
Los Angeles, CA 90046
Telephone number is: (323) 436-5000

- d. Members should include the date of submittal, member name, member ID, nature of grievance, persons involved, and any additional details related to the grievance. A PHP grievance form may also be submitted via email, fax, or US postal mail. PHP staff can assist with completion of the form upon request.
 - i. PHP staff who initially encounter the member reporting the grievance has the primary responsibility to address the concern and attempt to resolve the issue promptly.
 - ii. For verbal grievances that are submitted to PHP staff outside of Member Services, the PHP staff will document the grievance using the new online Grievance Submission Form and notify the Grievance and Appeals team directly of the grievance via email on the same day.
 - iii. For written grievances that are submitted to PHP staff outside of MS, PHP staff will date stamp the grievance on the day it was received by the Health Plan and forward it to the Member Services Department via fax or email on the same day.
- e. On no account may a member be discriminated against on the grounds that the member has filed a grievance. All primary care facility staff (including medical providers, administrative staff, etc.) are notified during training arranged by the MS/Enrollment leadership team, and reminded that members filing complaints or with intentions to disenroll may not be discriminated against. A filed grievance or intent to file a grievance does not impede clinical or medical care provided to the complainant as a member of the PHP Health Plan.

4. Logging grievances

- a. The Member Services Department or any Plan staff can document grievances received by the Plan in the PHP Member Services Module or via the new online Grievance Submission form located at <https://positivehealthcare.net/florida/php/for-members/complaint> . All grievances received by telephone are documented objectively, from the member's perspective by the PHP staff who initially encounter the member.
- b. After documenting the complaint, the Member Services agent or the Health Plan staff will notify the Grievance and Appeal Department of the complaint by sending an email to <mailto:QIGrievancesCAFL@aidhealth.org> for triage.
- c. The Grievance Coordinator will triage and review the case details to confirm if the issue is resolved or needs further investigation.
- d. The Grievance Coordinator will determine if the grievance contains multiple issues and issue an acknowledgement letter, using the appropriate template (QOC versus Non-QOC).

- e. When a beneficiary files a grievance and then files a subsequent grievance on the same exact issue prior to the organization's decision or the deadline for decision notification (whichever is earlier), the issue is counted as one grievance.
- f. If the grievance was filed by an individual representing the member, a valid Appointment of Representative (AOR) form or Equivalent Written Notice (EWN) must be received.
 - i. The enrollee and purported representative will be notified, in writing, that the grievance is not valid until documentation is provided.
 - 1. The receipt date of the grievance will be entered on the date that the AOR form / EWN is received.
 - ii. If the AOR form / EWN is not received within thirty (30) calendar days, the grievance will be dismissed as unable to process. If requested by the member, the timeframe to receive the AOR form / EWN form can be extended to an additional fourteen (14) days.
 - 1. An EWN includes the following:
 - a. Name, address, and telephone numbers of the enrollee and the individual being appointed
 - b. Enrollee's Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier, or plan ID number
 - c. The appointed representative's professional status or relationship to the party
 - d. A written explanation of the purpose and scope of the representation
 - e. A statement that the enrollee is authorizing the representative to act on his or her behalf for the claim(s) at issue, and a statement authorizing disclosure of individually identifying information to the representative
 - f. A statement by the individual being appointed that he or she accepts the appointment and is signed and dated by the enrollee and the individual being appointed.
- g. The grievance documentation should, at minimum, include the following elements:
 - i. CMS Contract Number;
 - ii. Plan Benefit Package Number;
 - iii. The member's name and Member ID#;
 - iv. The Grievance Case ID;
 - v. Identifier for whether the grievance is related to Part C or Part D;



- vi. The date and time the grievance was received by the Health Plan;
- vii. The date and time the AOR form (if applicable) was received by the Health Plan;
- viii. Identify if an extension was taken to resolve grievance;
- ix. Identify if the grievance was expedited;
- x. The date and time the grievance was completed (organization notified member of its decision).
- xi. Grievance Categorization
 - 1. Part C: Dismissed, Enrollment/Disenrollment, Benefits Package, Access, Marketing, Customer Service, Organization Determination and Reconsideration Process, Quality of Care, Other Grievances related to "CMS Issues"
 - 2. Part D: Dismissed, Enrollment/ Disenrollment, Plan Benefits, Pharmacy Access, Marketing, Customer Service, Coverage Determinations and Redeterminations Process, Quality of Care, Other Grievances related to "CMS Issues".

5. Acknowledging the Grievance

PHP will issue a written acknowledgment within five (5) calendar days of receipt of a grievance.

- a. The acknowledgment will advise the member that the grievance has been received, the date of receipt, and provide the name and contact number of the Grievance and Appeals coordinator who may be contacted about the grievance.
- b. The TTY/TTD telephone numbers, the Plan's address, telephone number and internet address shall be displayed on all PHP grievance acknowledgment and resolution letters.
- c. For QOC grievances, the acknowledgement letter will include a description of the enrollee's right to file a grievance with the BFCC-QIO and contact information for the BFCC-QIO:

Livanta
 BFCC-QIO Program
 10820 Guilford Road, Suite 202
 Annapolis Junction, MD 20701
 (877) 588-1123
 TTY (855) 887-6668
 Fax (833) 868-4063

6. Grievance Investigation

- a. The Grievance Coordinator will collaborate with the appropriate departmental manager or delegated vendor/ provider/facility for prompt review and investigation.



- b. Grievances related to QOC issues shall be include involvement by the Health Plan's Medical Director, or his/her designee. Any designee will be a Medical Director with appropriate clinical expertise in treating the member's condition or disease.
- c. The member has a reasonable opportunity to present, in writing or in person before the individual(s) resolving the grievance, evidence, facts and law in support of their grievance. PHP will comply with a member's request to review records in connection with a grievance.

7. Grievance Resolution

- a. PHP issues grievance resolution letters upon completion of the investigation, which must be delivered no later than thirty (30) calendar days of receipt of the request and be written in a manner that is understandable to the enrollee. The written resolution contains a clear and concise explanation of the Health Plan's decision. PHP does not disclose information to the grievant that is confidential or privileged by law, such as disciplinary action towards employees of the Health Plan or contractors, or specific details regarding the results of a quality of care investigation marked confidential by law.
- b. If the enrollee's representative submits a request, the representative must be notified in lieu of the enrollee. Plans may send written notice to both the representative and enrollee, but are not required.
- c. For QOC grievances, resolution letters will:

- i. Include a description of the enrollee's right to file a written complaint with the BFCC-QIO and contact information for the BFCC-QIO:

Livanta
 BFCC-QIO Program
 10820 Guilford Road, Suite 202
 Annapolis Junction, MD 20701
 (877) 588-1123
 TTY (855) 887-6668
 Fax (833) 868-4063

- ii. Quality of care grievances may be received and acted upon by the plan, the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), or both.
 - 1. For any grievance submitted to the BFCC-QIO, plans must cooperate with the BFCC-QIO in resolving the grievance, including directing providers to respond to BFCC-QIO requests for information, within fourteen (14) days. Plans should provide any records and requested information as quickly as possible and within fourteen (14) days.
- iii. Decisions made under the grievance process are not subject to appeal.

8. General Timelines for Responding to Grievances

- a. Grievance investigations will be completed as expeditiously as possible.



i. Written Grievances

1. Notification must be delivered no later than thirty (30) days of receipt for standard grievances and no later than twenty-four (24) hours for expedited grievances.
2. Verbal notification is considered delivered on the date (and time, if applicable) a plan speaks directly to or leaves a voicemail for an enrollee or enrollee's representative. Plans may initially provide verbal notification prior to issuing written notification.
 - a. In circumstances when verbal notification is permitted per regulatory requirements and the plan successfully provides verbal notice (e.g., spoke with the person that submitted the request or was able to leave a voicemail message), the plan must send the required written notice within three (3) calendar days of the verbal notice. If the plan is not able to successfully provide verbal notice (i.e., when a plan has an enrollee's telephone number on file, but is unable to reach the enrollee at the number provided because, for example, it is either incorrect, out-of-service, or no person (or no voicemail system) answers), written notice must be sent within the applicable timeframe.
 - b. Unless otherwise specified, written notification is considered delivered on the date (and time, if applicable) the notice has left the possession of the plan or delegated entity. Generally, this occurs when the notice has been deposited in the courier drop box or external outgoing mail receptacle (e.g., U.S. Postal Service or FedEx bin). Placement into the plan or delegated entity's internal outgoing mail receptacle is not considered delivered.
 - c. Electronic notification is considered delivered as of the date the plan sends it, not when the enrollee opens or accesses it.

ii. Verbal Grievances

1. Timeframes are identical to the timeframes for written grievances, as indicated above.
2. However, if a verbal grievance can be resolved during the same call /interaction by the Plan staff that is documenting the grievance, the Health Plan must document details of the resolution, and proceed to log and report the call as a grievance. Please see Section "4-c-i" for additional guidance related to reporting a grievance that is resolved during the same call/interaction. The grievance team will send a notification letter, informing the member that the issue was logged for tracking/trending within ten (10) days of the receipt date.

- b. The Health Plan may take a fourteen (14) day extension if the enrollee requests the extension or if the plan justifies a need for additional information and documents how the delay is in the best interest of the enrollee.
 - i. The Health Plan promptly notifies the enrollee in writing if the extension is going to be taken and explain the reason for the delay.

9. Expedited Grievances

- a. Grievances are considered an expedited request when:
 - i. Part C: When an enrollee disagrees with the Health Plan's decision to invoke an extension for an expedited determination / appeal or denies the request for an expedited organization determination or reconsideration/appeal
 - ii. Part D: When an enrollee disagrees with the Health Plan's decision to grant an enrollee's request for an expedited coverage determination or redetermination/appeal, and the enrollee has not yet purchased or received the drug that is in dispute.
- b. In such cases, the following will apply:
 - i. PHP will provide verbal notification must be delivered no later than twenty-four (24) hours from receipt.
 - ii. PHP shall deliver written confirmation of its decision within three (3) calendar days of the verbal notification.
 - iii. If the grievance is submitted by a member's representative, Member Services makes every effort to obtain verbal consent from the member to speak with the representative before taking the grievance. A written form shall be obtained following the verbal confirmation.
 - 1. If the enrollee's representative submits a request, the representative must be notified in lieu of the enrollee. Plans may provide notice to both the representative and enrollee, but are not required.

10. Withdrawn Grievances

- a. An enrollee may submit a written withdrawal request for a grievance any time before the decision is mailed by the plan. The plan may accept verbal withdrawals for both written and verbal grievances received from an enrollee. The plan must clearly document in the system that the enrollee does not want to proceed with the grievance procedures. The plan should, but is not required to, send a written confirmation of that withdrawal to the enrollee within three (3) calendar days of receiving the withdrawal request. If the enrollee submits a quality-of-care grievance verbally or in writing, but later decides to withdraw the grievance, the plan is still required to investigate the quality of care grievance; however, the plan is not required to notify the enrollee of the outcome of the grievance since they decided not to pursue the grievance.

11. Grievance Reporting

- a. PHP uploads all Part C and D grievances to the Health Plan Management System (HPMS) per the required categories and submitted to a CMS approved external auditor for data validation annually.
- b. Grievances are reported internally to the PHP Compliance Department at least quarterly.

Definitions:

1. **Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO):** Organizations comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. The BFCCQIOs review enrollee complaints about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities (SNFs), home health agencies (HHAs), Medicare managed care plans, Medicare Part D prescription drug plans, and ambulatory surgical centers. The BFCC-QIOs also review continued stay denials in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs, and comprehensive outpatient rehabilitation facilities (CORFs). In some cases, the BFCC-QIO can provide informal dispute resolution between the health care provider (e.g., physician, hospital, etc.) and enrollee.
2. **Dismissal:** A decision not to review a request for a grievance, initial determination, or appeal because it is considered invalid or does not otherwise meet Medicare Advantage or Part D requirements.
3. **Enrollee:** An eligible individual who has elected a Medicare Advantage, Prescription Drug, or cost plan or health care prepayment plan (HCPP).
4. **Grievance:** An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or a Late Enrollment Penalty (LEP) determination.
5. **Inquiry:** Any verbal or written request for information to a plan or its delegated entity that does not express dissatisfaction or invoke a plan’s grievance, coverage or appeals process, such as a routine question about a benefit.
6. **Quality of Care (QOC) Grievance:** A grievance related to whether the quality of covered services provided by a plan or provider meets professionally recognized standards of health care, including whether appropriate health care services have been provided or have been provided in appropriate settings
7. **Representative:** Under Part C, as defined in §422.561, an individual appointed by an enrollee or other party, or authorized under state or other applicable law, to act on behalf of an enrollee or other party involved in a grievance, organization determination, or appeal. Part D, §423.560 defines “representative”, as an individual either appointed by an enrollee or authorized under state or other applicable law to act on behalf of the enrollee in filing a grievance, obtaining a coverage determination, or in dealing with any of the levels of the appeals process. For both Part C and Part D, unless otherwise provided in the applicable law the representative will have all of the rights and responsibilities of an enrollee or other party, as applicable.



8. Withdrawal: A voluntary verbal or written request to rescind or cancel a pending grievance, initial determination, or appeal request submitted by the same party.

Monitoring:

1. Manual quality audits are completed by the Clinical Risk Manager, or designee, at least quarterly.
2. An HPMS format report is generated and reviewed against the tracking log.
 - a. Grievance data are submitted to PHP's Member and Provider, Quality Management, Risk Management and Executive Oversight Committees for review and appropriate action at least quarterly. The Committees shall take appropriate action to remedy any problems identified in its reviews.
 - b. The quarterly reporting of data described above will be reviewed in the aggregate to determine opportunities for quality improvement. The Clinical Risk Manager will make recommendations as needed to address the findings.
3. This policy is updated as necessary and reviewed and approved at least annually by the Risk Management Committee.

References(s):

1. Federal Regulations at 42 CFR 422, Subpart M
2. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance

