

## Chapter 13

# Member Grievances and Appeals Process For Dual-Eligible Special Need Programs

### Overview

Member grievances and appeals are highly regulated by federal and state agencies. Each health plan contracting with the Centers for Medicare and Medicaid Services (CMS) and the Minnesota Department of Human Services (DHS) is required to have a Grievance System for handling member grievances and appeals. The Minnesota Department of Health (MDH) also requires each health plan to have a process in place to handle complaints and appeals. These processes address Quality of Care (QOC) Complaints handling as well. Additionally, South Country incorporates information pertaining to these processes, from the National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans.

South Country's CMS and DHS contracts require that a provider be informed of South Country's Grievance System within sixty days after the execution of a contract with South Country. This chapter outlines these important procedures and responsibilities for SeniorCare Complete and AbilityCare Programs (Dual Eligible Special Need Plans). Dual-Eligible Special Need Plans provide Medicare Parts A, B, and D services pursuant to the Medicare Modernization Act (MMA) and the Medical Assistance Medical Care Program, a public health benefits program, intended to provide members with access to cost-effective low-income health care options. This chapter outlines these important procedures and responsibilities for South Country's SeniorCare Complete and AbilityCare Programs. More information can be obtained by contacting South Country.

### Definitions

**Please note: The term enrollee and member may be interchanged throughout this Chapter. Please refer to Chapter 15 for Medicaid (State of Minnesota) and NCQA definitions.**

**Appeal (CMS-Part C):** Any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by the Medicare health plan and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.

**Appeal (CMS-Part D):** Any of the procedures that deal with the review of adverse coverage determinations made by the Part D plan sponsor on the benefits under a Part D plan the enrollee believes he or she is entitled to receive, including a delay in providing or approving the drug coverage (when a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for the drug coverage, as defined in §423.566(b). These procedures include redeterminations by the Part D plan sponsor, reconsiderations by the

independent review entity (IRE), Administrative Law Judge (ALJ) hearings, reviews by the Medicare Appeals Council (MAC), and judicial reviews.

**Complaint (CMS-Part C):** Any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. This can include concerns about the operations of providers or Medicare health plans such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to enrollees, the claims regarding the right of the enrollee to receive services or receive payment for services previously rendered. It also includes a plan's refusal to provide services to which the enrollee believes he or she is entitled. A complaint could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process.

**Complaint (CMS-Part D):** A complaint may involve a grievance, coverage determination, or both. A complaint also may involve a late enrollment penalty (LEP) determination. Every complaint must be handled under the appropriate process.

**Coverage Determination (CMS-Part D):** Any decision made by or on behalf of a Part D plan sponsor regarding payment or benefits to which an enrollee believes he or she is entitled.

**Effectuation (CMS-Part C):** Compliance with a reversal of the Medicare health plan's original adverse organization determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.

**Effectuation (CMS-Part D):** Payment of a claim, authorization or provision of a benefit the plan sponsor has approved, or compliance with a complete or partial reversal of a Part D plan sponsor's original adverse coverage determination.

**Grievance (CMS-Part C):** Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which South Country provides health care services, regardless of whether any remedial action can be taken. An enrollee or their representative may make the complaint or dispute, either orally or in writing to South Country, provider, or facility. An expedited grievance may also include a complaint that South Country refused to expedite an organization determination or reconsideration or invoked an extension to an organization determination or reconsideration time frame.

In addition, grievances may also include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

**Grievance (CMS-Part D):** Any complaint or dispute, other than a coverage determination or an LEP determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Part D plan sponsor, regardless of whether remedial action is requested. A grievance may also include a complaint that a Part D plan sponsor refused to expedite a coverage determination or redetermination. Grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided item.

**Organization Determination (CMS):** Any determination made by a Medicare health plan with respect to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;
- Payment for any other health services furnished by a provider other than the Medicare health plan that the enrollee believes are covered under Medicare, or, if not covered

under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan;

- The Medicare health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Medicare health plan;
- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment;
- Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee; *or*
- Medicare Savings Accounts (MSA) only: Decisions regarding whether expenses, paid for with money from the MSA Bank Account or paid for out of pocket, constitute Medicare expenses that count towards the deductible; and, prior to satisfying the deductible, decisions as to the amount the enrollee had to pay for a service.

**Quality Improvement Organization (QIO) (CMS-Part C and D):** 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. QIOs review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, (Medicare Part D prescription drug plans for Part D) and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in skilled nursing facilities (SNFs), home health agencies (HHAs) and comprehensive outpatient rehabilitation facilities (CORFs).

**Quality of Care Issue (CMS-Part C and D):** A quality of care complaint may be filed through the Medicare health plan's grievance process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by a Medicare health plan meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

**Reconsideration (CMS-Part C):** An enrollee's first step in the appeal process after an adverse organization determination; a Medicare health plan or independent review entity may re-evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

**Redetermination (CMS-Part D):** The first level of the appeal process, which involves a Part D plan sponsor reevaluating an adverse coverage determination, the findings upon which it was based, and any other evidence submitted or obtained.

**Representative (CMS-Part C):** 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 an appeal or grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of an enrollee or party in obtaining an organization determination, filing a grievance, or in dealing with any of the levels of the appeals process, subject to the applicable rules described at 42 CFR Part 405.

**Representative (CMS-Part D):** 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,

requesting a coverage determination, or in dealing with any of the levels of the appeals process. Unless otherwise stated in part 423, subpart M of the Medicare Part D regulations, the representative has all of the rights and responsibilities of an enrollee in obtaining a coverage determination or in dealing with any of the levels of the appeals process, subject to the rules described in part 422, subpart M of the Medicare Part C regulations.

**Spouse:** The word “spouse” as used in Chapter 18 of the Prescription Drug Benefit Manual, and as used in section 423.2052(a)(5) of title 42 of the C.F.R. regarding the dismissal of an appeal includes same-sex spouses as well as opposite-sex spouses. The relationship of two individuals of the same sex will be recognized as a marriage if either (1) the state or territory in which the individuals live recognizes their relationship as a marriage, or (2) the individuals entered into a legally valid marriage under the law of any state, territory, or foreign jurisdiction. Because civil unions and domestic partnerships are not marriages, civil union and domestic partners are not regarded as spouses by CMS.

## Process

**Please note: Please refer to Chapter 15 for processes regarding Medicaid-only services, including information related to State Fair Hearings (i.e. State Appeals).**

Per CMS requirements, South Country must establish and maintain procedures for:

- Standard and expedited organization determinations;
- Standard and expedited appeals; and
- Standard and expedited grievances.

South Country must have a grievance system in place that includes a grievance process, an appeal process and access to the State Fair Hearing (also called State Appeal) system

For Members enrolled in South Country’s SeniorCare Complete (MA02) program, South Country must:

- assure compliance with Medicare and Medicaid requirements,
- preserve member’ access to all appropriate levels of Medicare and Medicaid appeals, and
- integrate both processes to make the system easier to navigate for the member.

For Members enrolled in South Country’s AbilityCare (MA17) program, this system must include a Medicare process for Medicare covered services and a Medicaid process for Medicaid covered services. AbilityCare members have the right to choose which or both processes to pursue. The overall system must:

- Assure compliance with Medicare and Medicaid requirements, and
- Preserve members access to all appropriate levels of Medicare and Medicaid appeals, and
- To the extent possible, work with the State to integrate both processes to make the system easier to navigate for the member.

Members enrolled in these two programs have CMS Medicare and DHS Medicaid coverage; thus, have both CMS Medicare and DHS Medicaid appeal rights for any Medicare and Medicaid covered service/issue. If the appeal issue relates to a service/issue covered by both Medicare and Medicaid, Medicare and Medicaid guidelines are used in making the determination and

corresponding appeal rights, as appropriate, are given. If the service/item is only covered by Medicare or Medicaid, but not both, the appropriate guidelines and appeal process is used.

Appeals may be filed orally or in writing and must be filed within sixty (60) calendar days from the date of the notice of the Part C organization determination or within sixty (60) calendar days from the date printed or written on the written Part D coverage determination denial notice.

Grievances may be filed orally or in writing and must be filed no later than sixty (60) calendar days after the event.

Members have the right to appoint or authorize a representative to act on their behalf during the grievance and appeal process. Please refer to the CMS Medicare Managed Care Manual-Chapter 13 and CMS Prescription Drug Benefit Manual-Chapter 18 for further rules regarding required documentation for an appointed or authorized member representative and for further guidance on when a provider can request an appeal without a completed representative form or written authorization.

South Country gives members any reasonable assistance in completing forms and taking other procedural steps, including but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

Please direct members, who wish to file a grievance or appeal with South Country, to call the Member Services phone number listed on the back of their South Country ID card. Member Services staff are trained to help members initiate these processes.

### **QOC Complaints**

South Country's Grievance and Appeals (G/A) Department oversees and handles member QOC complaints. These QOC complaints may relate to quality of care or services. The G/A department will request information from the involved practitioner/provider, to comply with regulations to thoroughly investigate the allegation; information requested may include member medical records, a provider written response to the allegation, written policies/procedures, etc. South Country will notify the practitioner/ provider of the outcome when the investigation has been completed.

If allegations are substantiated, next steps may include, but are not limited to:

- Recommendation for education or re-training
- Provider submission of a corrective action plan;
- Referral to the South Country Provider Network/Credentialing staff for further action.

Unsubstantiated allegations are closed and tracked for possible trends.

### **Member Communication of QOC Complaints**

Under state law, any information reviewed via our QOC peer review process, is protected information and these outcomes are not disclosed to the member. The member will however be notified that the investigation has been completed.

Members are also informed that they can file a QOC complaint directly to Medicare's QIO either in writing or by telephone:

- Livanta
  - By phone to: 1-888-524-9900 (toll free) (TTY: 1-888-985-8775)

- In writing to:  
Livanta  
10820 Guilford Road, Suite 202  
Annapolis Junction, MD 20701  
Attention: Beneficiary Complaints
- **OR Members can access the Medicare Quality of Care concern form on Livanta's website at [www.livantaqio.com](http://www.livantaqio.com)** and can fax the completed form to 1844-420-6671.

### Grievance Process

- South Country does not require that a grievance be filed in writing as a condition of taking action on a grievance.
- All grievances are investigated and a decision on a grievance is made by an individual not involved in any previous level of review or decision-making.
- If South Country is deciding a grievance regarding the denial of an expedited resolution of an appeal or one that involves clinical issues, the individual making the decision must be a health care professional who is the same or similar general specialty as typically manages the medical condition, procedure, or treatment under discussion. South Country will make a determination in accordance with the timeframe for an expedited appeal.
- The findings or outcome and actions related to the grievance are communicated to the member. Per State law, Quality of Care complaint/ grievance outcomes are not communicated to the member.
- For Medicare grievances, the resolution timeframe for both oral and written grievances (without an extension) is 30 days. Grievances filed orally, may be responded to orally. Written grievances must be responded to in writing. All QOC grievances must be responded to in writing.
- South Country may extend the timeframe for resolution of a grievance by an additional 14 days if the member or the practitioner/provider requests the extension, or if South Country justifies that due to a need for additional information, the extension is in the member's interest. South Country provides written notice to the member of the reason for the decision to extend the timeframe if South Country determines that an extension is necessary. South Country issues a notice of resolution no later than the date the extension expires.
- The member also has a right to file a grievance with external agencies. They can contact CMS by calling 1-800-633-4227 (toll-free) or visiting Medicare's website (<http://www.medicare.gov>). The member can file a grievance either verbally or in writing with:
  - MDH
    - Members can call 612-201-5100 (Twin Cities metro) or 1-800-657-3916 (toll free greater Minnesota) or
    - Members can write to:  
Minnesota Department of Health  
Managed Care Section

P.O. Box 64882  
St. Paul, MN 55164-0882

- Minnesota Department of Human Services (DHS) Managed Health Care Ombudsman.
  - Member can call 651-431-2660 (Twin Cities metro) or 1-800-657-3729 (toll free greater Minnesota) or
  - Members can write to:  
Minnesota Department of Human Services  
Ombudsman Office for Public Managed Health Care Programs  
P.O. Box 64249  
St. Paul, MN 55164-0249

### **Appeal Process**

- The member must first request an appeal through South Country's appeal process.
- For a member expedited request not supported by a physician, South Country must determine whether the life or health of the member, or the member's ability to regain maximum function, could be seriously jeopardized by applying the standard time frame in the processing of the reconsideration request.
- If South Country denies a member request for an expedited appeal, South Country will transfer the denied request to the standard appeal process, preserving the first date of the expedited Appeal. South Country will promptly give oral notification of this decision to the member and inform the member of any additional rights and also send this information to the member via a written letter within three calendar days. South Country will not take punitive action against a practitioner/provider who requests an expedited appeal or supports a member's appeal.
- For a Part C reconsideration (i.e. appeal), if South Country determines to fully or partially uphold a denial, South Country will auto-forward the appeal case to the Independent Review Entity contracted with CMS to initiate the next level of appeal. Please refer to the CMS Medicare Managed Care Manual-Chapter 13 for information pertaining to this process and additional levels of appeal.
- The member, authorized representative or the attending health care professional/practitioner may provide additional information regarding the appeal in person, by telephone, or in writing. For an expedited appeal resolution, this information must be presented as soon as possible.
- South Country must include as parties to an appeal the member, authorized representative or the legal representative of a deceased member's estate.
- For Medicare oral appeals, South Country is required to send a written acknowledgement letter to the member to confirm the facts and basis of the appeal. South Country ensures the individual making the decision was not involved in any previous level of review or decision-making.
- South Country must designate someone other than the person involved in making the initial organization determination when reviewing a Part C reconsideration (appeal). If the original denial was based on a lack of medical necessity, then the reconsideration must be performed by a physician with expertise in the field of medicine that is appropriate for the services at issue. The physician need not, in all

cases, be of the same specialty or subspecialty as the treating physician. The physician must, however, possess the appropriate level of training and expertise to evaluate the necessity of the service. This does not require that the physician always possess identical specialty training. The member is informed in writing of the appeal decision. Resolution timelines (without extensions) for Part C reconsiderations are:

- *Expedited Appeal:* As expeditiously as the member's health warrants, but no later than 72 hours after receiving the request. South Country will also notify the member and the attending health care professional by telephone of its determination as per the above timeframe.
- *Standard Appeal:* As expeditiously as the member's health warrants, not to exceed 30 calendar days after the receipt of the appeal.
- Resolution timelines (without extensions) for Part D redeterminations are:
  - *Expedited Appeal:* As expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request.
  - *Standard Appeal:* As expeditiously as the enrollee's health condition requires, but no later than seven (7) calendar days from the date the Part D plan sponsor receives the request for a standard redetermination. Please refer to CMS requirements for more information regarding when a request is deemed received by a health plan.
- South Country may take an extension of up to 14 additional days for both an expedited appeal and standard appeal to make the decision if the member requests the extension or South Country justifies an extension is in the member's best interest. For an expedited appeal, South Country will provide an oral and written notice to the member of the reason for the decision to extend the timeframe and any additional rights for filing an expedited grievance. For a standard appeal, South Country will provide written notice to the member of the reason for the decision to extend the timeframe and any additional rights for filing an expedited grievance. South Country will communicate the final appeal determination no later than the date the extension expires.
- The member has an opportunity, before and during the appeals process, to review their file, including medical records and any documents and records considered during the appeal process.
- The member may request and receive copies of all documents relevant to the appeal, free of charge, upon request.
- The member has the right to a fast-track appeal when they disagree that their covered SNF, HHA or CORF services should end. CMS contracts with the QIO to conduct fast-track appeals.
- When a member has Medicare and is going to be discharged from a health care facility, skilled services, etc., the provider/facility will give the member a written notice about the discharge, which explains how the member can appeal the discharge (e.g. depending on provider type, this might be "An Important Message from Medicare" or "Notice of Medicare Non-Coverage"). If the member chooses to file an appeal, the member should follow the appeal instructions included in this written notice and should call Livanta's HelpLine at 1-888-524-9900 (TTY 1-888-985-8775). The provider entities are responsible for ensuring these notices contain the appropriate and applicable QIO contact information.

