Chapter 13

Member Grievances and Appeals Process For Dual-Eligible Special Needs Plans

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 Health Alliance (South Country) incorporates information pertaining to these processes, when applicable, 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 Needs Plans (D-SNPs)). D-SNPs 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 14 for Medicaid (State of Minnesota) definitions.

Appeal: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services or drug coverage (when the delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR 422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a Level 1 appeal), a reconsideration by an Independent Review Entity (IRE), adjudication by an Administrative Law Judges (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review.

Initial Determination: A decision made by the plan, or its delegated entity, on a request for coverage (payment or provision) of an item, service, or drug (known as either a coverage determination or organization determination)

Integrated appeal: Any of the procedures that deal with, or result from, adverse integrated organization determinations by an applicable integrated plan on the health care services the 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. Integrated appeals cover

procedures that would otherwise be defined and covered, for non-applicable integrated plans, as an appeal defined in §422.561 or the procedures required for appeals in accordance with §§438.400 through 438.424. Such procedures include integrated reconsiderations.

Applicable integrated plan means:

(1) A fully integrated dual eligible special needs plan with exclusively aligned enrollment or a highly integrated dual eligible special needs plan with exclusively aligned enrollment, and

(2) The Medicaid managed care organization, as defined in section 1903(m) of the Act, through which such dual eligible special needs plan, its parent organization, or another entity that is owned and controlled by its parent organization covers Medicaid services for dually eligible individuals enrolled in such dual eligible special needs plan and such Medicaid managed care organization.

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 BFCC-QIOs 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.

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.

Effectuation: Authorization or provision of a benefit that a plan has approved, payment of a claim, or compliance with a complete or partial reversal of a plan's original adverse determination.

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 an LEP determination.

Integrated grievance: A dispute or complaint that would be defined and covered, for grievances filed by an enrollee in non-applicable integrated plans, under §422.564 or §§438.400 through 438.416. Integrated grievances do not include appeals procedures and QIO complaints, as described in §422.564(b) and (c). An integrated grievance made by an enrollee in an applicable integrated plan is subject to the integrated grievance procedures in §§422.629 and 422.630.

Independent Review Entity (IRE): An independent entity contracted by CMS to review adverse level 1 appeal decisions made by the plan. Under Part C, an IRE can review plan dismissals.

Quality of Care 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.

Reconsideration: Under Part C, the first level in the appeals process which involves a review of an adverse organization determination by an MA plan, the evidence and findings upon which it was based, and any other evidence submitted by a party to the organization determination, the MA plan or CMS. Under Part D, the second level in the appeals process which involves a review of an adverse coverage determination by an independent review entity (IRE), the evidence and findings upon which it was based, and any other evidence the enrollee submits or the IRE obtains.

Integrated reconsideration: A reconsideration that would otherwise be defined and covered, for a non-applicable integrated plan, as a reconsideration under §422.580 and appeal under §438.400(b). An integrated reconsideration is made by an applicable integrated plan and is subject to the integrated reconsideration procedures in §§422.629 and 422.632 through 422.634.

Redetermination: The first level of the Part D appeal process, in which the plan sponsor reviews an adverse Part D coverage determination, including the findings upon which the decision was based, and any other evidence submitted or obtained.

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. Under Part D, as defined in §423.560 as "appointed representative", 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 & Part D, the representative will have all of the rights and responsibilities of an enrollee or other party, as applicable.

Withdrawal: A verbal or written request to rescind or cancel a grievance, initial determination, or appeal.

Process

Please note: Please refer to Chapter 14 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 an integrated grievance can be filed at any time

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 online "Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance", and the "Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans", 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, or when the provider must give the enrollee notice of filing the appeal (see 42 CFR § 422.629(l)(1)(ii), and (l)(3)). For cases involving only a Medicaid-covered benefit, an applicable integrated plan may accept a written authorization from an enrollee that complies with state Medicaid requirements, even if such an authorization does not contain every element described under Section 20.2 of the above referenced CMS online Parts C and D guidance.

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.

Members who wish to file a grievance or appeal with South Country may be directed 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 any follow-up recommendation determined by South Country's Medical Director, or physician designee, when the investigation has been completed.

If a quality of care or services issue is identified, 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.

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 for a Part C or Part D (Medicare) QOC grievance.

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 and can fax the completed form to 1-844-420-6671.

Grievance Process

- South Country does not require that a grievance be filed in writing as a condition of taking action on a grievance.
- For integrated grievances, South Country will send a grievance acknowledgement letter to the member.
- 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 within two calendar days 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 also contact the following State agencies with their concern:
    - MDH
        - Members can call 1-612-201-5100 (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 1-651-431-2660 (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 integrated 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 two 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 send the appeal case to the Independent Review Entity contracted with CMS to initiate the next level of appeal (Level 2 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 and all integrated reconsiderations (DSNP 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. Part B prescribed drug appeals have a seven (7) calendar day processing timeframe that cannot be extended.
- 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 (except for Part B prescribed drug appeals) to make the decision if the member requests the extension or South Country justifies an extension is in the member's best interest and there is a need for additional information and a reasonable likelihood that receipt of such information would lead to approval of the request, if received. 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. The written notice of the extension will be completed within two calendar days of the attempt of prompt oral notice. 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.

- If the provider requests that the benefits continue while an integrated appeal is pending, pursuant to 42 CFR § 422.632 and consistent with State law, the provider must obtain the written consent of the enrollee to request the integrated appeal on behalf of the enrollee.
- If via appeal the initial determination is reversed, South Country will authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than effectuation timeframes established via regulatory or contractual requirements.
- 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.