Chapter 14

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.

Appeal (CMS): 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 (DHS): An oral or written request from the member, or the Provider acting on behalf of the member with the member's written consent, to the health plan for review of an action.

Appeal (NCQA): A request to change an adverse decision made by the organization. A member or authorized representative of a member may appeal any adverse decision.

Coverage Determination: 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.

Expedited Appeal: a request from an attending health care professional, a member, or their representative, that South Country reconsider its decision to wholly or partially deny authorization for services as soon as possible but no later than 72 hours after receiving the request because the member's life, health, or ability to regain maximum function could be jeopardized by waiting 30 calendar days for a decision. The request is made prior to or during an ongoing service.

Grievance (DHS Contract): Any expression of dissatisfaction about any matter other than an action, including but not limited to, the quality of care or services provided or failure to respect the member's rights.

Grievance (CMS Contract): Any complaint or dispute, other than an organization determination (or coverage determination for Part D), 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: (NCQA): a request for an organization to change a decision. See appeal (NCQA).

Health Care Professional: : A physician, optometrist, chiropractor, psychologist, dentist, advanced dental therapist, dental therapist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed independent clinical social worker, and registered respiratory therapy technician.

Medical Necessity: A health service, pursuant to Minnesota Rules, Part 9505.0175, subpart 25, that is: 1) consistent with the member's diagnosis or condition; 2) is recognized as the prevailing standard or current practice by the provider's peer group; and 3) is rendered:

a. In response to a life threatening condition or pain, or
b. To treat an injury, illness or infection, or
c. To care for the mother and child through the maternity period; or to achieve a level of physical or mental function consistent with prevailing community standard for diagnosis or condition, or
d. As a preventive health service defined under Minnesota Rules, Part 9505.0355.

Notice of Action: Notice of Action includes a Denial, Termination, or Reduction of Service Notice (DTR) or other Action as defined in 42 CFR 438.400(b).

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.

Practitioner (NCQA): A licensed or certified professional who provides medical or behavioral health care services.

Provider (NCQA): An institution or organization that provides services, such as a hospital, residential treatment center, home health agency or rehabilitation facility.

Quality Improvement Organization (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. 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, 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 SNFs, HHAs and CORFs.

Quality of Care Issue (CMS): 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): 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.

Representative: 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.

State Fair Hearing: a hearing filed according to a member's written request with the State (Department of Human Services) related to:

- the delivery of health services or participation in the Managed Care Organization (MCO);
- denial (full or partial) of a claim or service;
- failure to make an initial determination in 30 days; or
- any other Action

Process

South Country must have a grievance system in place that includes a grievance process, an appeal process, and access to the State Fair Hearing system.

- For SeniorCare Complete: assure compliance with Medicare and Medicaid requirements,

- Preserve SeniorCare Complete members' access to all appropriate levels of Medicare and Medicaid appeals, and
- Integrate both processes to make the system easier to navigate for the SeniorCare Complete members.

For AbilityCare, 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 system must:

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

Members 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.

If an AbilityCare or Senior Care Complete member chooses to file an appeal through the Medicare process under 42 CFR § 422.582, the member must file an appeal within sixty (60) days from the date of the notice of the organization determination, unless the member shows good cause for not doing so. Nothing shall prevent a SeniorCare Complete or AbilityCare member from pursuing both the Medicare and Medicaid appeal process simultaneously.

Grievances may be filed orally or in writing, and depending on whether the grievance relates to Medicaid or Medicare services, the time period for filing the grievance may be no later than 60 days after the event (CMS) or within 90 days from the date of the event (DHS).

Members have the right to designate a representative to act on their behalf during the grievance and appeal resolution process. A practitioner/provider may initiate a grievance or appeal on behalf of a member with a member's written permission. Please refer to the CMS Medicare Managed Care Manual, Chapter 13, Section 70.1.1 for further rules regarding 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, in order 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 Credentialing Committee 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:

- KEPRO
  - Members can call 1-855-408-8557 (toll free) or
  - Can write to:
    KEPRO
    5201 W. Kennedy Blvd
    Suite 900
    Tampa, FL 33609

  - *OR Fax: 844-834-7130*

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. Quality of Care complaint/ grievance outcomes are not communicated to the member.
- For Medicaid grievances, the verbal grievance outcome may be communicated verbally or in writing within 10 calendar days from the receipt of the grievance (this timeframe does not include an extension).
- For Medicaid grievances, the written grievance outcome is communicated in writing within 30 calendar days from the receipt of the grievance. South Country sends out an acknowledgement letter to the member and/or the practitioner/provider acting on member's behalf within 10 days of receiving a written grievance. This may also include the grievance outcome if a decision has been made within 10 days (this timeframe does not include an extension).
- 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.
- For Medicaid oral grievances, any outcome that is adverse, either in part or in whole, or not satisfactory to the member, the member is informed of their right to file a written grievance.
- Members may appeal any adverse grievance decision that affects the member's ability to receive benefit coverage, access to care, access to services or payment for care of services through South Country's appeal process. Appeal rights are not applicable for grievances in which there is no adverse decision to appeal.

- 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 may request an appeal either through South Country's appeal process or by requesting a State Fair Hearing with DHS (also referred to as "the State"). The member or their representative can appeal at any time to DHS about an action taken by South Country.
- A member is not required to exhaust South Country's appeal process before requesting a State Fair Hearing ; the member can choose to file an appeal with South Country and request a State Fair Hearing at the same time.
- South Country will accept an expedited request when an initial DTR determination is made prior to or during an on-going service, and if the attending health care professional/practitioner believes that the determination warrants an expedited appeal. A member's request for an expedited appeal, without physician support, will be reviewed to see if it meets the expedited criteria.
- If South Country denies a request for 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 notify the member of that decision orally within twenty-four (24) hours of the request and follow up with a written notice within two days.

- South Country will not take punitive action against a practitioner/provider who requests an expedited appeal or supports a member's appeal.
- If a member files an appeal with South Country before the date of the action proposed on the DTR and **requests** continuation of benefits within the time allowed, South Country may not reduce or terminate the service until 10 days after a written decision is issued to that appeal, unless:
    - The member withdraws the appeal, or
    - If the member requested a State Fair Hearing with a continuation of benefits, until the State Fair Hearing decision is reached.
- The continuation of benefits is not required if the practitioner/provider who orders the service is not a participating practitioner/provider with South Country or authorized nonparticipating practitioner/provider.
- South Country cannot continue the service if the service is a Medicare-only covered service per Title XVIII of the Social Security Act.
- If the appeal is filed orally; South Country will assist the member, or practitioner/ provider acting on the member's behalf, in completing a written **signed** appeal. Once the oral appeal has been placed in writing and is pending the member's signature, South Country must:
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    - Resolve the appeal in favor of the member, regardless of the receipt of the member's signature, or
    - if no signed appeal is received within 30 days, South Country may resolve as if a signed appeal were received
- For Medicare requests for a hearing, the AbilityCare member may choose the Medicare process for Medicare covered services.
- For services covered by Medicare, South Country must follow 42 CFR § 422.600 through 616, which includes member access to review by an IRE, Administrative Law Judge, Medicare Appeals Council and Judicial Review.
- The attending health care professional/practitioner may appeal utilization review decisions without the written consent of the member in accordance with MN Statutes § 62M.06 within ninety (90) days of the DTR Notice of Action or any other action taken by SCHA as it is defined in 42 CFR § 438.400(b).
- 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 decreased member's estate.
- South Country sends a written acknowledgement within 10 days of receiving the appeal and may combine it with South Country's notice of resolution if a decision is made within 10 days.
- South Country ensures the individual making the decision was not involved in any previous level of review or decision-making.
- If the appeal requires a medical necessity determination, a determination will be made by a board-certified physician who did not make the initial determination, is

not a subordinate of the initial reviewer, and who is the same or similar general specialty as typically manages the medical condition, procedure, or treatment under discussion.

- The member is informed in writing of the appeal decision. If the appeal involves a UM decision, the attending health care professional/practitioner will also be informed of the appeal decision. If the resolution is adverse to the member, the member will be informed of their right to request a State Fair Hearing. Resolution timelines (without extensions) 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.
- 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 notice to the member of the reason for the decision to extend the timeframe. For a standard appeal, South Country will provide written notice to the member of the reason for the decision to extend the timeframe. South Country will communicate the decision 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 is notified of the right to request an immediate Quality Improvement Organization (QIO) review if the member believes he/she is being prematurely discharged from the hospital.
- Members receive notification of termination of Medicare services provided by a skilled nursing facility, home health agency or comprehensive outpatient rehabilitation facility. Members also have the right to appeal such termination to an Independent Review Entity (IRE).

State Fair Hearing Process

The member (or the provider acting on behalf of the member, with the member's written consent) must request a State Fair Hearing (appeal) within 30 days of the DTR notice or written action by South Country or within 90 days if the member shows a good reason for not submitting the request within the 30-day time limit (pursuant to MN Statute 256.045).

A State Fair Hearing can be requested in the following ways:

- Write to:
  Minnesota Department of Human Services
  Appeals Office
  PO Box 64941
  St. Paul, MN 55164-0941

  File online: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG

  Or fax to: 1-651-431-7523

- If a member makes a written request for a State Fair Hearing with the State, and requests continuation of benefits within the time allowed before the date of a proposed action in either South Country's DTR notice or written appeal decision, South Country may not reduce or terminate a service until a written decision is issued by the State in the State Fair Hearing or the member withdraws the request for a State Fair Hearing.
- in the case of a reduction or termination of ongoing services, services must be continued, pending outcome of all appeal hearings if: (1) there is an existing order for services by the treating and participating practitioner/provider; or (2) the treating and participating practitioner/provider orders discontinuation of services and another participating practitioner/provider orders the service, but only if that practitioner/ provider is authorized by his/her contract with the South Country to order such services.
- Prior to the scheduled hearing date, South Country reviews the appeal information that is received, and if necessary, initiates a subsequent review process to review new information, or reopens the case to correct any errors identified with the original denial determination. If no additional action is needed, South Country completes the State Agency Appeals Summary form and submits this form, along with all necessary documentation, at least three days before the scheduled hearing. .
- During the State Fair Hearing, South Country representatives present testimony and defend the determination that was made.
- Following the hearing, a recommendation is made by the DHS Human Services Judge, with the final order decided by the Commissioner of Human Services.
- South Country will comply with the Commissioner's final order promptly and as expeditiously as the member's health condition requires.