

Chapter 15

Member Grievances and Appeals Process for Medicaid Programs

Overview

Member grievances and appeals are highly regulated by federal and state regulations. Each health plan contracting with 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 also requires each health plan to have a process in place to handle complaints and appeals. These processes also address Quality of Care Complaints handling.

SCHA contract with DHS requires that provider be informed of SCHA's Grievance System at the time a provider enters into a contract with SCHA. This chapter outlines these important procedures and responsibilities for Minnesota Health Care Programs (Medicaid). Contact SCHA for more information about the grievances and appeals process.

This Chapter Includes:

Minnesota Health Care Programs Member Grievance and Appeal Process for the following SCHA's products:

- Prepaid Medical Assistance Program,
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- MinnesotaCare Program, and
- Minnesota SeniorCare Plus Program.

Definitions

Grievance: any expression of discontent or dissatisfaction about any matter other than SCHA's denial, termination or decrease of a requested service. This includes, but is not limited to, discontent with:

- Quality of care or services provided including long wait times for appointments, interpersonal aspects of care, such as rudeness by a provider or staff member (other than refusal to furnish a requested service)
- Failure to respect member's rights.

Appeal: a request for a reconsideration of a denial, termination or reduction of a requested service. The request is made prior to or during an ongoing service.

Any grievance requiring a medical determination in its resolution is processed under the appeal procedure by SCHA. This may include:

- The denial or decrease in the type or level of service,
- The decrease, suspension, or stopping of a service that was approved previously
- The denial of all or part of payment of a service, or
- Other authorized health care services.

Expedited Appeal: a request from an attending health care professional, a member, or their representative, that SCHA 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.

State Fair Hearing: a hearing filed according to a member's written request with the State related to:

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

Process

Members or their representative may file a grievance or an appeal by telephone or in writing with SCHA within 90 days from the date of dissatisfaction or notification of the denial, termination, or reduction (DTR) of services. See the definitions above.

Members have the right to designate a representative to act on their behalf during the grievance and appeal resolution process. A provider may initiate a grievance or appeal on behalf of a member with a member's written permission. Members must sign a Release of Information form acknowledging that the representative has their permission to review confidential information pertinent to the grievance or appeal. The attending health care professional may appeal utilization review decisions at the health plan level without the written signed consent of the member.

SCHA 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 SCHA, to call the Member Services phone number listed on the back of their SCHA ID card. Member Services staff are trained to help members initiate the complaint or appeal.

Quality of Care Complaints

SCHA's Grievance and Appeals Department directs and oversees the quality of care complaint program. The Grievance and Appeals Department investigates quality of care complaints which may involve clinical or service quality. The Grievance and Appeal Coordinator evaluates each complaint and may request provider input or medical records to validate the allegations. SCHA will notify the provider in writing of the outcome when the investigation has been completed.

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

- Case closure and tracking to monitor possible trends;
- Request the provider to submit a corrective action plan;
- Referral to the Credentialing Committee for further action.

Unsubstantiated allegations are closed and tracked for possible trends.

Member Communication of Quality of Care Complaints

Under state law, any information received is protected by peer review process. Any communication regarding the case is not subject to a subpoena or discovery in any civil action. At the time the complaint is received, the member receives an acknowledgement letter. The member is not informed of the decision as outlined in the legal requirements relating to the peer review process.

Grievance Process

- SCHA 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 SCHA 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 with appropriate clinical expertise in treating the member's condition or disease. SCHA 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.
- The verbal grievance outcome may be communicated verbally or in writing within 10 calendar days from the receipt of the grievance.
- The written grievance outcome is communicated in writing within 30 calendar days from the receipt of the grievance. SCHA sends out an acknowledgement letter to the member or the provider acting on member's behalf within 10 days of receiving a written grievance. This may also include the grievance outcome is a decision has been made within 10 days.
- SCHA may extend the timeframe for resolution of a grievance by an additional 14 days if the member or the provider requests the extension, or if SCHA justifies that due to a need for additional information, the extension is in the member's interest. SCHA provides written notice to the member of the reason for the decision to extend the timeframe if SCHA determines that an extension is necessary. SCHA issues a notice of resolution no later than the date the extension expires.
- For grievance outcomes that are 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 if they had filed a verbal grievance.
 - receives a copy of the Member Rights, which outlines additional rights the member may have.
- The member also has a right to file a grievance with an external agency. The member can file a grievance either verbally or in writing with:
 - Minnesota Department of Health (MDH). This is the agency that regulates HMOs in Minnesota.

- Members can call 612-282-5600 (Twin Cities metro) or 1-800-657-3916 (toll free greater Minnesota) or
- Can write to MDH:
 - Minnesota Department of Health*
 - Health Policy and Systems Compliance Division*
 - Managed Care Systems*
 - 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
 - Can write to DHS:
 - Minnesota Department of Human Services*
 - Ombudsman Office for Managed Health Care Programs*
 - P.O. Box 64249*
 - St. Paul, MN 55164-0249*

Appeal Process

- The member may request an appeal either through SCHA'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 SCHA. A member is not required to exhaust SCHA's grievance and appeal system before requesting a State Fair Hearing.
- SCHA will accept an expedited request when an initial DTR determination is made prior to or during an on-going service, and the attending health care professional 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 SCHA denies a request for expedited appeal, SCHA will transfer the denied request to the standard appeal process, preserving the first date of the expedited Appeal. SCHA 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.
- SCHA will not take punitive action against a provider who requests an expedited appeal or supports a member's appeal.
- If a member files an appeal with SCHA before the date of the action proposed on the DTR and requests continuation of benefits within the time allowed, SCHA 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,
 - 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 provider who orders the service is not a participating provider with SCHA or authorized nonparticipating provider.

- If the appeal is filed orally; SCHA will assist the member, or 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, SCHA may:
 - Resolve the appeal in favor of the member, regardless of the receipt of the member's signature, or
 - Resolve the appeal within 30 days if no signed appeal is received within 30 days.
- The member or the attending health care professional 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.
- SCHA sends a written acknowledgement within 10 days of receiving the appeal and may combine it with SCHA's notice of resolution if a decision is made within 10 days.
- SCHA 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 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, procedures, 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 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 are:

- *Expedited Appeal*: As expeditiously as the member's health warrants, but no later than 72 hours after receiving the request. SCHA 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.
- SCHA may take an extension of up to 14 additional days to make the decision if the member requests the extension or SCHA justifies the need for more information and an extension is in the member's interest. SCHA will provide written notice to the member of the reason for the decision to extend the timeframe. SCHA 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.

State Fair Hearing Process

- If a member makes a written request for a State Fair Hearing to the State before the date of a proposed action in either SCHA's DTR notice or written appeal decision, SCHA may not reduce or terminate a medical service that has been ordered by a participating or treating provider until the State issues a written decision.

- The member must appeal within 30 days after receiving a DTR notice or written appeal decision by SCHA or one of its contracted entities of action, decision, or final disposition, or within 90 days if the member shows a good reason for not submitting the request within the 30-day time limit.
 - The member can write to:
Minnesota Department of Human Services
Appeal Office
444 Lafayette Road North
St. Paul, MN 55155-3813
- Prior to the State Fair Hearing, SCHA reviews the initial determination or action and makes a determination if the initial decision should be overturned before the State Fair Hearing or if the decision stands.
- If the appeal goes to State Fair Hearing, SCHA representatives present the action taken and the basis or reason for the action. The member or their representative then responds with the reason why they feel the decision was not correct, and why they need the type and level of service in dispute, or why SCHA should pay for a service already received.
- The decision is made by the DHS Referee and the order is sent to SCHA. SCHA will comply with the decision in the State Fair Hearing promptly and as expeditiously as the member's health condition requires