Chapter 14

Member Grievances and Appeals Process For Minnesota HealthCare (Medicaid) Programs

Overview

Member grievances and appeals are highly regulated by federal and state agencies. Each health plan contracting with the Minnesota Department of Human Services (MN DHS) is required to have a Grievance System in place that includes a grievance process, an appeals process and access to the State Fair Hearing (also called State Appeal) system. This Grievance System includes the handling and processing of any member Quality of Care (QOC) complaints. When applicable, South Country Health Alliance (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 contract with DHS requires that a provider be informed of South Country's Grievance and Appeal System at the time the provider enters into a contract with South Country and also requires South Country to provide an explanation of the member and provider grievance, appeal and state fair hearing rights to the provider within 60 days after the execution of a contract with South Country. This chapter outlines these important procedures and responsibilities for Minnesota Health Care Programs (Medicaid), which includes the following South Country Programs: Prepaid Medical Assistance Program (PMAP), MinnesotaCare, Minnesota Senior Care Plus, SingleCare and SharedCare. Both SingleCare and SharedCare are a Special Needs Basic Care Program (SNBC). More information can be obtained by contacting South Country.

Definitions

Action: 1) the denial or limited authorization of a requested service, including decisions based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit, 2) the reduction, suspension, or termination of a previously authorized service; 3) the denial, in whole or in part of payment for a service; 4) the failure to provide services in a timely manner 5) the failure of the MCO to act within the timeframes defined in Article 8 regarding the standard resolution of grievances and appeals; 6) denial of an enrollee's request to dispute a financial liability, including cost sharing, or, 7) for a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right to obtain services outside the network. Action means the same as "adverse benefit determination" in 42 CFR §438.400(b).

Appeal: 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.

Grievance: 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.

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 advance practice registered nurse, clinical nurse specialist, certified registered

nurse anesthetist, and certified nurse midwife), licensed independent clinical social worker, and registered respiratory therapy technician.

Medically Necessary or Medical Necessity: a health service that is: 1) consistent with the member's diagnosis or condition; 2) 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
b. To treat an injury, illness or infection;
c. To treat a condition that could result in physical or mental disability;
d. To care for the mother and unborn child through the maternity period;
e. To achieve a level of physical or mental function consistent with prevailing community standard for diagnosis or condition; or
f. As a preventive health service defined under Minnesota Rules, Part 9505.0355 (Minnesota Rules, Part 9505.0175, subpart 25).

Notice of Action: A Denial, Termination, or Reduction of Service Notice (DTR) or other action as defined above.

State Fair Hearing or State Appeal: A hearing filed according to a member's written request with the State (Department of Human Services) pursuant to MN Statutes 256.045, related to:

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

Process

Members, a member's authorized representative or a member's provider (with or without written consent as it pertains to the type of request) may file a grievance or an appeal with South Country, orally or in writing. Appeal requests need to be filed within 60 days of the date of the DTR Notice, or for any other action taken by the MCO as defined above and in 42 CFR 438.400(b). More time may be allowed if the member has a good reason for missing the deadline. There is no timeframe filing requirement for Medicaid grievances.

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 during the grievance and appeal processes.

Members who wish to file a grievance or an appeal directly with South Country, may call the Member Services phone number listed on the back of their South Country ID card for further assistance. Members can also access grievance and appeal forms on South Country's website.

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; or
- Referral to the Credentialing Committee for further action.

Member Communication of QOC Complaint Outcomes

Under state law, any information reviewed via our QOC peer review process, is protected information and these findings/outcomes are not disclosed to the member.

Grievance Process

- South Country does not require that a grievance be filed in writing as a condition of acting on a grievance.
- All member grievances that meet filing requirements 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 with appropriate clinical expertise in treating the member's condition or disease. South Country will make a determination in accordance with the timeframe for an expedited appeal.
- The findings or outcome (disposition) and actions related to the grievance are communicated to the member. (As mentioned above, QOC findings/outcomes are not disclosed to the member).
- An oral grievance outcome may be communicated verbally or in writing within ten (10) calendar days from the receipt of the grievance (this timeframe does not include an extension; see below for more information regarding extensions).
- A written grievance outcome is communicated in writing within thirty (30) calendar days from the receipt of the grievance (this timeframe does not include an extension). South Country sends out an acknowledgement letter to the member and/or the practitioner/provider acting on member's behalf within ten (10) days of receiving a written grievance. This may also include the grievance outcome if a decision has been made within ten (10) days.
- 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 an extension is in the member's best interest. South Country must make reasonable efforts to provide prompt oral notice and provide written notice within two (2) 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.
- For oral 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 and South Country offers to assist the member with this process (see below for additional member oral grievance rights for options with further review by the

Minnesota Department of Health (MDH) or assistance from the managed care ombudsperson).

- Appeal rights are not applicable for complaints in which there is no adverse decision to appeal.
- When resolving oral and written grievances, the member is also informed of their options for further review by MDH or assistance from the managed care ombudsperson and MDH. Contact information for these external agencies, is as follows:
    - 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 ombudsperson.
        - Members 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
          The Office of Ombudsperson 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 before requesting a State Fair Hearing (i.e. State Appeal) with DHS (also referred to as "the state"). Per 42 CFR §438.402, the MCO may have only one level of appeal for members. Multiple reviews by different personnel within the MCO are not construed as multiple levels of appeal. Regardless of the personnel reviewing an appeal, the review must not extend any of the timeframes specified in 42 CFR §438.408 and must not disrupt the continuation of benefits in 42 CFR §438.420.
- South Country will accept an expedited appeal request when an initial DTR determination is made prior to or during an on-going service, and if the attending health care professional believes that the determination warrants an expedited appeal (i.e. the provider feels that waiting the standard 30 days could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain, or regain maximum function). 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 24 hours of the request and follow up with a written notice within two (2) 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 ten (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 practitioner/provider who orders the service is not a contracted practitioner/provider with South Country or authorized non-contracted practitioner/provider.
- The attending health care professional/practitioner may appeal utilization review decisions without the written consent of the member.
- 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, South Country will inform the member/appellant of the limited time available to present evidence in support of the appeal.
- South Country must include as parties to an appeal the member, authorized representative or the legal representative of a deceased member's estate.
- South Country sends a written acknowledgement letter within ten (10) days of receiving the appeal and may combine it with South Country's notice of resolution if a decision is made within ten (10) days.
- South Country ensures the individual making the decision was not involved in any previous level of review or decision-making, also ensures this individual is not a subordinate of the person who made the previous decision.
- If South Country is deciding an appeal regarding (1) a denial of a service based on lack of medical necessity (2) a grievance regarding the denial of an expedited resolution of an appeal or (3) an appeal that involves clinical issues, South Country must ensure that the individual making the decision is a health care professional with appropriate clinical expertise in treating the enrollee's condition or disease.
- 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 (state appeal). Resolution timelines (without extensions) are:
    - *Expedited appeal:* As expeditiously as the member's health condition warrants, but no later than 72 hours after receiving the request. South Country will also notify the member and the attending health care professional/practitioner by telephone of its determination as per the above timeframe.
    - *Standard appeal:* As expeditiously as the member's health condition 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. South Country must make reasonable efforts to provide prompt oral notice and provide written notice within two (2) calendar days to the member of the reason for the decision to extend the

timeframe if South Country determines that an extension is necessary. This notice will include the member's right to file a grievance regarding the delay (if the extension involves an expedited appeal, then the member will be notified of the right to file an expedited grievance). 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 and sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c)

State Fair Hearing (i.e. State Appeal) Process

The member (or the provider acting on behalf of the member, with the member's written consent) must request a state fair hearing (state appeal) after exhaustion of South Country's appeals process but no later than one hundred and twenty (120) days from the date of South Country's written notice of appeal resolution, consistent with 42 CFR §438.408(f)(2).

A state fair hearing can be requested in the following ways:

- Write to:
  Minnesota Department of Human Services
  Appeals Division
  PO Box 64941
  444 Lafayette Blvd

  St. Paul, MN 55164-0941
- Phone: 1-651-431-3600; Toll Free: 1-800-657-3510; TTY: 711 or 1-800-627-3529
- 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, South Country, in accordance with 42 CFR §438.420(b) and Minnesota Statutes, §256B.69, subd.18, may not reduce or terminate the service until a written decision is issued by the state in the state fair hearing or the member withdraws the request for the state fair hearing. "Within the time allowed" means the request is made on or before the date that is ten (10) days after South Country sends its notice of resolution of appeal.
- In the case of a reduction or termination of ongoing services, services must be continued, pending outcome of all appeal or state fair hearings if there is an order for services by an authorized provider, consistent with 42 CFR §438.420(b)(3)
- 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 (3) business (working) 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. Consistent with 42 CFR §431.244(f), the STATE must take final administrative action on any request for a State Fair Hearing within ninety (90) days of the date the request for a state fair hearing was filed (the State must take final administrative action for expedited state fair hearings within three (3) business days of receipt of the file from the health plan).
- South Country will comply with the Commissioner's final order promptly and as expeditiously as the member's health condition requires.