Point32Health

The Who, What, Where, and When of Appeals and Grievances

Tufts Health Plan Senior Care Options

Grievances defined

“Any expression of discontent”

Per CMS: A grievance is 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 or prescription drug services or benefits, regardless of whether remedial action is requested.

https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Grievances

Member Rights

- You can file a complaint about services you got, other concerns or problems you have in getting health care, or the quality of the health care you got.
- If you're concerned about the quality of the care you received, you have the right to file a complaint.
- If you have a Medicare Advantage Plan, Medicare drug plan, or other Medicare health plan, call the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), your plan, or both.

BFCC-QIO for MA & CT is **KEPRO**

https://www.keproqio.com

https://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf

What is the health plan's responsibility?

As a Medicare plan, CMS requires that THP have:

- A meaningful procedure for the timely resolution of grievances between enrollees and the plan or any of its delegated entities
- A written grievance procedure, provided to members upon enrollment, involuntary disenrollment, annually and upon request

In the plan's grievance process:

- Enrollees are not required to use specific language to initiate a grievance
- The Plan must consider grievances separately from inquiries, coverage requests or appeals – customer service representatives receive additional training to make these determinations and route them appropriately

Types of grievances

Administrative Grievance: A complaint concerning business proc
plan; These grievances may be resolved over the phone duri
initial call, but can still be recorded as a grievance

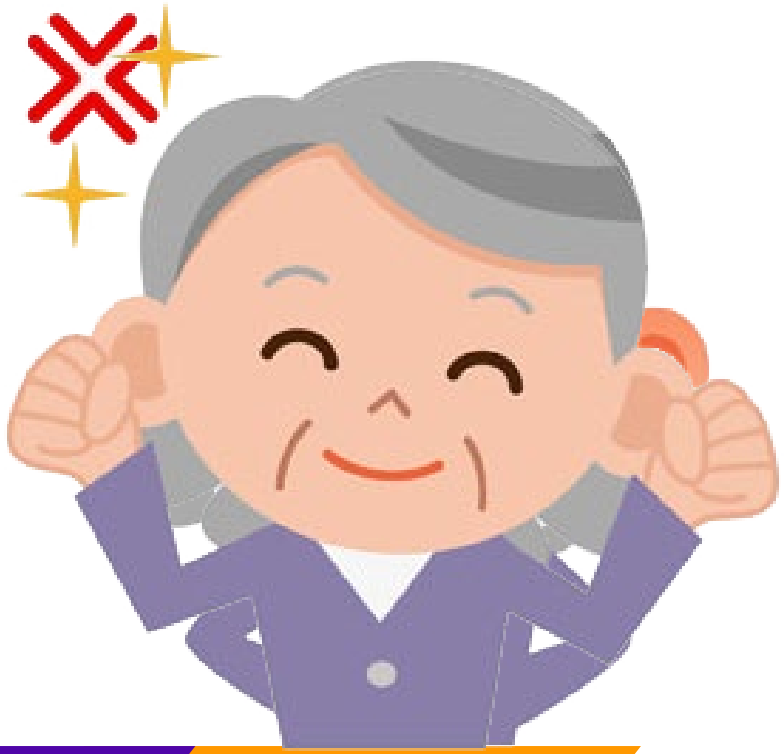
Clinical Grievance: A complaint concerning the quality of care a r
These grievances may also be reviewed by Clinical Quality/C
completes their review

Expedited Grievance: If a member disagrees with Tufts Medicare on
to extend the timeframe for a determination or Tufts Medicare s to
grant an expedited OD, CD, or Appeal, this complaint is cons ed
grievance

Appeals & Grievances reviews each grievance to determine what type it is and how it needs to be responded to

What should I do if I receive a member complaint?

1. LISTEN.
2. Make sure you understand the complaint. Ask questions to check for understanding.
3. If you can offer one or more solutions, ask if the member would be interested or if the solution(s) would help.
4. Ask, "**Would you like to file this complaint as a grievance? That will allow Point32Health to document and investigate so we can improve our program.**"



Filing a grievance

Assist the member in contacting
Member Relations at **1-855-670-5934**

or

Document in CaseTrakker with a Grievance Note, then email to
AG_Coordinator_Team@point32health.org

You are not responsible for categorizing, investigating or responding to member grievances, but the process must be offered to members for all complaints.

What? – Reconsiderations

Medicare Part C Reconsideration – Definition

- An enrollee's first step in the appeal process after an adverse organization determination
- A Medicare health plan or Independent Review Entity (IRE) may reevaluate an adverse OD, the findings upon which it was based, and any other evidence submitted or obtained

Additional Part C Appeal Guidelines

- Standard Part C Appeals must be submitted in writing
- Expedited Appeals may be submitted orally by member or physician
- Appeals must be filed within 60 calendar days from the denial notification unless "just cause" is shown
- The member, their authorized representative, or treating provider can request a reconsideration (providers do not have to be an authorized representative to file an appeal on the member's behalf)

What? – Reconsiderations

Medicare Part D Reconsideration – Definition

- 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

Additional Part D Appeal Guidelines

- Standard Part D Appeals can be submitted orally or in writing
- Expedited Appeals may be submitted orally by member or physician
- Appeals must be filed within 60 calendar days from the denial notification unless “just cause” is shown
- The Plan has to accept and process expedited Part D appeals 24/7
- The member, their authorized representative, or treating provider can request a reconsideration (providers do not have to be an authorized representative to file an appeal on the member’s behalf)

Where?

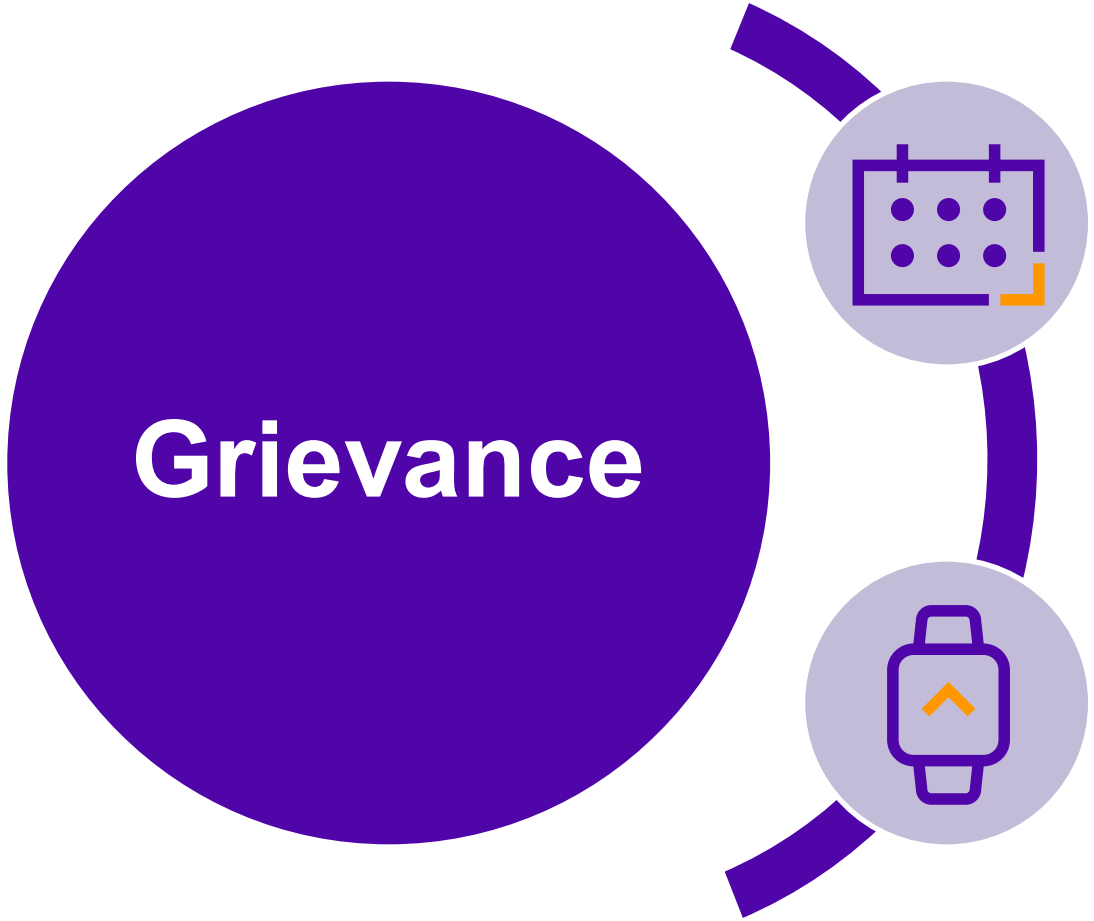
Appeals

- Reconsideration decisions are made in a weekly multidisciplinary appeals committee
- All upheld Reconsiderations must be forwarded to the IRE
- Redetermination decisions are made by covering MD

Grievances

- Administrative Grievances can be responded to by phone or in writing
- Clinical Grievances and Grievances received in writing must always be responded to in writing

When? – Timeframes



Standard: 30 days

Expedited: 24 hours

…or as expeditiously as a member's health demands.

When? – Timeframes

Appeals (Part C)

Standard (pre service): 30 days

Standard (post service): 60 days

Expedited: 72 hours

…or as expeditiously as a member's health demands.

When? – Timeframes

Appeals (Part D)

Standard: 7 days

Expedited: 72 hours

…or as expeditiously as a member's health demands.

Documentation Dos and Do Nots

Do

- Document completely, clearly, concisely and accurately
- Document in a timely manner (in real time/on the date of communication)
- Use spellcheck/proper grammar
- Use only standardized, acceptable abbreviations
- Document with both current and future viewers/reviewers of the record in mind

Do Not

- Document prior to the event
- Copy and paste emails into member records
- Editorialize or include unnecessary emotion
- Give excuses or place blame
- Explicitly document when issues are referred to Quality Management

SCO Appeals & Grievances Contacts

- For further information on filing an appeal or grievance – contact **Point32Health Customer Relations** at **1-855-670-5934**
- For further information on filing an appeal through the Executive Office of Health and Human Services (EOHHS), contact the following:

  Board of Hearings
  Office of Medicaid
  100 Hancock Street, 6th Floor
  Quincy, MA 02171
  Phone: 1-617-847-1204
  Fax: 1-617-847-1200