



Health Plan Division's Policies and Procedures

Medicare Part D Grievance Policy

Policy Number: HPS-MCR-002

Adopted: 1/1/2006

Revised: 12/1/2008

PURPOSE

EXPLANATION: Group Health Cooperative (GHC) has a Medicare Advantage Prescription Drug (MAPD) contract with the Center for Medicare and Medicaid Services (CMS) to provide Medicare benefits to GHC MAPD members. Under the terms of the contract, GHC is required to have Grievance procedures for their enrollees that adhere to all processing standards and timeframes set by CMS.

POLICY

DESCRIPTION: As a Medicare Part D contractor, GHC acts as the Medicare carrier for Group Health enrollees and therefore is responsible for administering drug benefits and providing clinical and allied health care services to Part D enrollees per their specific Medicare Medical Coverage Plan.

Grievances are handled within the Health Plan, through the health plan's **internal** complaint and appeal process. The *Principles for Decision Making* will serve as a guideline for decisions. The Service Quality infrastructure processes Medicare enrollee grievance requests and consults with Medicare Administration when appropriate, to determine the best resolution to the enrollee's complaint. Grievances are **not** sent to CMS for their determination. All Medicare grievances must follow CMS criteria as established the Prescription Drug Benefit Manual (Chapter 18).

PROCEDURES

IMPLEMENTING MEDICARE PART D GRIEVANCE POLICY

Note: These procedures provide additional information related to a Division, Corporate Operational Policy 900-206, but are separate and distinct from that policy. Leadership retains discretion in implementing these procedures and can change them at any time, with or without notice.

REPRESENTATION

Enrollee's right to representation: Grievance requests may be submitted by a Medicare enrollee, or by a representative authorized by the enrollee. CMS regulations require that both parties complete and sign an Appointment of Representative form in which the

enrollee authorizes the second party to represent him/her in the grievance **OR** that a copy of the Durable Power of Attorney with a health care provision is provided which authorizes the second party to represent the enrollee in the grievance.

If an unauthorized party requests a grievance review, and no formal written authorization of representation has been received from the Medicare enrollee, written notification of this requirement will be sent to the unauthorized (second) party. In all cases, if the enrollee's attorney files the grievance, an Appointment of Representative form is not necessary.

TIMEFRAMES

The enrollee must file their grievances no later than 60 days after the event or incident that precipitates the grievance.

GHC will acknowledge all grievances orally or in writing within 5 business days of receipt. All Quality of Care grievances will be acknowledged in writing.

GHC will notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee's health status, but no later than 30 days after the date the oral/written grievance is received.

GHC may extend the 30-day timeframe by up to 14 days if the enrollee requests the extension or if GHC justifies a need for additional information and documents how the delay is in the interest of the enrollee. If an extension is requested by GHC, GHC will notify the enrollee in writing of the reason(s) for the delay.

GHC will respond within 24 hours to any grievances that are made in regards to a refusal by GHC to grant an enrollee's request for an expedited coverage determination or an expedited appeal and the enrollee has not yet purchased or received the drug that is in dispute.

APPLICABILITY:

This policy applies to the Service Quality infrastructure: Group Health Customer Service, Member Quality, Appeals, and Clinical Staff when handling complaint and grievance requests as defined above. The health plan does not delegate the review of Grievances. All Grievances received in Appeals or clinical settings will be forwarded to Health Plan Service for review and disposition

RESPONSIBILITIES:

Administration of this policy is the responsibility of Group Health Cooperative's Health Plan Service, Appeals, and/or Clinical Staff.

Audits are conducted quarterly. A sample set of grievances are reviewed using the WS-GV1 audit tool to determine if the grievances were processed according to CMS guidelines. All grievance categories are reviewed to track and trend issues and provide feedback for process improvements. Corrective Action Plans are created for any areas that are not meeting the CMS standard.

DEFINITIONS:

Grievance

Any complaint or dispute, other than one that involves a coverage determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Part D plan sponsor, regardless of whether a remedial action is requested. Examples or possible subjects of grievances may include, but are not limited to complaints regarding:

- The quality of care or services provided.
- Interpersonal aspects of care, such as rudeness by a provider or staff member.
- Failure to respect an enrollee's rights.
- Pharmacy Copays and the cost of medication.
- Refusal to expedite a coverage determination or appeal.
- Part D Membership, enrollment, or dues issues.

Appeal

Any of the procedures that deal with the review of adverse coverage determinations made by the Part D plan sponsor on the benefits under a Part D plan the enrollee believes he or she is entitled to receive, including delay in providing or approving the drug coverage (when a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay drug coverage. These procedures include redetermination by the Part D plan sponsor, reconsiderations by the independent review entity (IRE), Administrative Law Judge (ALJ) hearings, reviews by the Medicare Appeals Council (MAC), and judicial reviews.

Complaint

Any expression of dissatisfaction to a Part D plan sponsor or provider by an enrollee made orally or in writing. This can include concerns about Part D plan sponsors or their contractors, such as; waiting times when you fill prescription, the way your network pharmacist or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of a network pharmacy. It also includes the plan's refusal to provide benefits an enrollee believes he or she is entitled to receive. A complaint could be either a grievance or an appeal, or a single complaint could include both. Every complaint must be handled under the appropriate grievance or appeal process.

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.

Quality of Care Issue

A Quality of care issue may be filed through the Part D plan sponsor's grievance process and/or Quality Improvement Organization (QIO). A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by a Part D plan sponsor meets professionally recognized standards of health care, including whether appropriate health care services have not been provided or have been provided in inappropriate settings. Quality of Care issues may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item.

REFERENCES:

CMS PDP Guidance Regulations, Chapter 18

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