

Appeals and Grievances Overview for CDPHP® Medicare Advantage Plan Members



Thank you for your interest in the CDPHP® Medicare Advantage plans offered by Capital District Physicians' Health Plan, Inc. and CDPHP Universal Benefits,® Inc. (referred to collectively herein as "CDPHP"). Our Medicare plans are Medicare Advantage Plans that contract with the Federal government and include:

- ▶ CDPHP Core (HMO)
- ▶ CDPHP Clear Rx (HMO)
- ▶ CDPHP Choice Rx (HMO)
- ▶ CDPHP \$0 Medicare Rx (HMO)
- ▶ CDPHP Group Medicare (HMO)
- ▶ CDPHP Group Medicare Rx (HMO)
- ▶ CDPHP Group Medicare (PPO)
- ▶ CDPHP Group Medicare Rx (PPO)

This overview is a general description of our Appeals and Grievance Process for members of our plans, and throughout this overview the plans will collectively be referred to as "CDPHP Medicare Advantage." Be mindful that it does not provide a detailed explanation of the Appeals and Grievance Process for each specific plan. To receive a complete description of our Appeals and Grievance Process for a specific plan, please call CDPHP and ask for the *Evidence of Coverage*.

What should you do if you have complaints about your Medicare Advantage benefits

Introduction

We encourage you to let us know right away if you have questions, concerns, or problems related to your covered services or the care you receive. Please call member services at the number on the cover of this booklet. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your medical care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from CDPHP or penalized in any way if you make a complaint.

What are appeals and grievances?

- ▶ An **"appeal"** is the type of complaint you make **when you want us to reconsider and change a decision we have made about what services or benefits are covered for you or what we will pay for a service or benefit.** For example, if we deny coverage or payment for services you think we should cover, you can file an appeal. If CDPHP or one of our plan providers denies you a service you think should be covered, you can file an appeal. If CDPHP or one of our plan providers reduces or cuts back on services or benefits you have been receiving, you can file an appeal. If you think we are stopping your coverage of a service or benefit too soon, you can file an appeal.

- A **“grievance”** is the type of complaint you make **if you have any other type of problem with CDPHP or one of our plan providers**. For example, you would file a grievance if you have a problem with things such as the quality of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor’s office.

This section is an overview of how to make complaints in different situations

- 1. Complaints about what we will cover for you or what we will pay for.** If CDPHP or your doctor or another plan provider has denied you a service you think is covered, you can make a complaint called an **appeal**. If we have denied payment for a service you think is covered for you, you can make an **appeal**. If you have been receiving a covered service, and you think that service is being reduced or ending too soon, you can make an appeal. When you file an appeal, you are asking us to reconsider and change a decision we have made about what services we will cover for you (which includes whether we will pay for your care or how much we will pay). You must submit your appeal to CDPHP in writing. *Please see Part 1 for more information.*
- 2. Complaints about your Part D prescription drug benefits that we will cover or pay for.** If CDPHP denied you a Part D prescription drug benefit that you think is covered, you can request an **appeal**. If we have denied payment for a Part D prescription drug that you have already received and you believe that it is covered, you can make an appeal. If you have been receiving a Part D prescription drug, and you think its coverage is being reduced or ending too soon, you can make an appeal. When you file an appeal, you are asking us to reconsider and change a decision we have made about what Part D prescription drug we will cover for you (which includes whether we will pay for a Part D prescription drug that you have already received, or how much we will pay). *The rules that apply to appeals of drug coverage are different than the rules that apply to your health benefits. Please see Part 2 for more information.*
- 3. Complaints if you think you are being discharged from the hospital too soon.** There is a special type of **appeal** that applies only to **hospital discharges**. If you think our coverage of your hospital stay is ending too soon, you can appeal directly and immediately to Livanta, which is the Quality Improvement Organization (QIO) in the state of New York. Livanta is a group of health professionals that is paid to handle this type of appeal from Medicare patients. If you make this type of appeal, your stay may be covered during the time period the QIO uses to make its determination. You must act very quickly to make this type of appeal, and it will be decided quickly. *Please see Part 1 for more information.*
- 4. Complaints if you think your coverage for Skilled Nursing Facility (SNF), Home Health (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.** There is another special type of appeal that applies only when coverage will end for **SNF, HHA, or CORF services**. If you think your coverage is ending too soon, you can appeal directly and immediately to Livanta, which is the Quality Improvement Organization for residents in the state of New York. If you make this type of appeal, your stay may be covered during the time period the QIO uses to make its determination. You must act very quickly to make this type of appeal, and it will be decided quickly. *Please see Part 1 for more information.*
- 5. Complaints about any other type of problem you have with CDPHP Medicare Advantage or one of our plan providers.** If you want to make a complaint about any type of problem other than those that are listed above, a grievance is the type of complaint you would make. For example, you would file a grievance to complain about problems with the quality or timeliness of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor’s office. Generally, you would file the grievance with CDPHP. But for many problems related to quality of care you get from plan providers, you can also complain to Livanta. *Please see Part 3 for more information.*

Part 1. Complaints (appeals) to CDPHP to change a decision about what services we will cover or what we will pay for

This part provides an overview of what you can do if you have problems getting the medical care you believe we should provide. We use the word “provide” in a general way to include such things as authorizing care, paying for care, arranging for someone to provide care, or continuing to provide a medical treatment you have been getting. Problems getting the medical care you believe we should provide include the following situations:

- ▶ If you are not getting the care you want, and you believe that this care is covered by CDPHP Medicare Advantage.
- ▶ If we will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by CDPHP Medicare Advantage.
- ▶ If you are being told that coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health. This includes inpatient hospital stays and SNF, HHA, and CORF services.
- ▶ If you have received care that you believe was covered by CDPHP Medicare Advantage while you were a member, but we have denied payment for this care.

Six possible steps for requesting care or payment from CDPHP Medicare Advantage:

If you are having a problem getting care or payment for care, there are six possible steps you can take to ask for the care or payment you want from us. At each step, your request is considered and a decision is made. If you are unhappy with the decision, you may be able to take another step if you want to continue requesting the care or payment.

- ▶ In Steps 1 and 2, you make your request directly to us. We review it and give you our decision.
- ▶ In Steps 3 through 6, people in organizations that are not connected to us make the decisions about your request. To keep the review independent and impartial, those who review the request and make the decision in Steps 3 through 6 are part of (or in some way connected to) the Medicare program or the federal court system.

Step 1: The initial decision by CDPHP

The starting point is when we make an “initial decision” (also called an “organization determination”) about your medical care or about paying for care you have already received. When we make an “initial decision,” we are giving our interpretation of how the benefits and services that are covered for members of CDPHP Medicare Advantage apply to your specific situation. You can ask for a “fast initial decision” if you have a request for medical care that needs to be decided more quickly than the standard time frame.

Step 2: Appealing the initial decision by CDPHP

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an “**appeal**” or a “request for reconsideration.” You can ask for a “fast appeal” if your request is for medical care and it needs to be decided more quickly than the standard time frame. After reviewing your appeal, we will decide whether to stay with our original decision, or change this decision and give you some or all of the care or payment you want.

Step 3: Review of your request by an Independent Review Organization

If we turn down part or all of your request in Step 2, we are **required** to send your request to an independent review organization that has a contract with the federal government and is not part of CDPHP. This organization will review your request and make a decision about whether we must give you the care or payment you want.

Step 4: Review by an Administrative Law Judge

If you are unhappy with the decision made by the independent review organization that reviews your case in Step 3, you may ask for an **Administrative Law Judge** to consider your case and make a decision. The Administrative Law Judge works for the federal government.

Step 5: Review by a Medicare Appeals Council

If you or we are unhappy with the decision made in Step 4, either of us may be able to ask a Medicare Appeals Council to review your case. This Council is part of the federal department that runs the Medicare program.

Step 6: Federal Court

If you or we are unhappy with the decision made by the Medicare Appeals Council in Step 5, either of us may be able to take your case to a Federal Court.

Part 2. Complaints (appeals) to CDPHP to change a decision about what Part D drugs we will cover or pay for (applicable for plans with Part D coverage only)

This section provides an overview of what you can do if you have problems getting the prescription drugs you believe we should provide. We use the word “provide” in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting. Problems getting a Part D prescription drug that you believe we should provide include the following situations:

- ▶ If you are not able to get a prescription drug that you believe may be covered by CDPHP Medicare Advantage.
- ▶ If you have received a Part D prescription drug you believe may be covered by CDPHP Medicare Advantage while you were a member, but we have denied payment for the drug.
- ▶ If we will not provide or pay for a Part D prescription drug that your doctor has prescribed for you because it is not on our formulary.
- ▶ If you disagree with the amount that we require you to pay for a Part D prescription drug that your doctor has prescribed for you.
- ▶ If you are being told that coverage for a Part D prescription drug that you have been getting will be reduced or stopped.
- ▶ If there is a requirement that you try another drug before we pay for the drug your doctor prescribed, or if there is a limit on the quantity (or dose) of the drug and you disagree with the requirement or dosage limitation.

Six possible steps for requesting a Part D benefit or payment from CDPHP Medicare Advantage

If you are having a problem getting a Part D benefit or payment for a Part D prescription drug that you have already received, there are six possible steps you can take to ask for the benefit or payment you want from us. At each step, your request is considered and a decision is made. If you are unhappy with the decision, you may be able to take another step if you want to continue requesting the benefit or payment.

- ▶ In Steps 1 and 2, you make your request directly to us. We review it and give you our decision.
- ▶ In Steps 3 through 6, people in organizations that are not connected to us make the decisions about your request. To keep the review independent and impartial, those who review the request and make the decision in Steps 3 through 6 are part of (or in some way connected to) the Medicare program or the federal court system.

Step 1: The initial decision by CDPHP

The starting point is when we make an “initial decision” (also called a “coverage determination”) about your Part D prescription drug or about paying for Part D drug that you have already received. When we make an “initial decision,” we are giving our interpretation of how the benefits that are covered for members of CDPHP Medicare Advantage apply to your specific situation. You can ask for a “fast initial decision” if you have a request for benefits that needs to be decided more quickly than the standard time frame.

Step 2: Appealing the initial decision by CDPHP

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an “**appeal**” or a “request for redetermination.” You can ask for a “fast appeal” if your request for benefits needs to be decided more quickly than the standard time frame. After reviewing your appeal, we will decide whether to stay with our original decision, or change this decision and give you the benefit or payment you want.

Step 3: Review of your request by an Independent Review Organization

If we turn down your request in Step 2, you may ask an independent review organization to review our decision. The independent review organization has a contract with the federal government and is not part of CDPHP. The independent review organization will review your request and make a decision about whether we must give you the benefit or payment you want.

Step 4: Review by an Administrative Law Judge

If you are unhappy with the decision made by the independent review organization that reviews your case in Step 3, you may ask for an Administrative Law Judge to consider your case and make a decision. The Administrative Law Judge works for the federal government.

Step 5: Review by a Medicare Appeals Council

If you are unhappy with the decision made in Step 4, you may be able to ask the Medicare Appeals Council (MAC) to review your case. The MAC is part of the federal department that runs the Medicare program.

Step 6: Federal Court

If you are unhappy with the decision made by the MAC in Step 5, you may be able to take your case to a Federal Court.

Part 3. Complaints (grievances) about any other type of problem you have with CDPHP Medicare Plans or one of our plan providers

This last section explains how to make complaints about any *other* type of problem that has not already been discussed earlier in this booklet. (The problems that have already been mentioned in Parts 1 and 2 are problems related to coverage or payment for care or Part D benefits, problems about being discharged from the hospital too soon, and problems about coverage for SNF, HHA, or CORF services ending too soon.)

What is included in “all other types of problems”?

Here are some examples of problems that are included in this category of “all other types of problems”:

- ▶ Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- ▶ If you feel that you are being encouraged to leave (disenroll from) CDPHP Medicare Advantage.
- ▶ Problems with the member service you receive.
- ▶ Problems with how long you have to spend waiting on the phone, in the waiting room, or in the exam room.
- ▶ Problems with getting appointments when you need them, or having to wait a long time for an appointment.
- ▶ Disrespectful or rude behavior by doctors, nurses, receptionists, or other staff.
- ▶ Cleanliness or condition of doctor’s offices, clinics, or hospitals.

If you have one of these types of problems and want to make a complaint, it is called “filing a grievance.” In addition, you have the right to ask for a “fast grievance” if you disagree with our decision to not give you a “fast appeal” or if we take an extension on our initial decision or appeal. See below for more detail.

Filing a grievance with CDPHP Medicare Advantage

If you have a complaint, we encourage you to first call member services at the number on the cover of this booklet. We will try to resolve any complaint that you might have over the phone. If you ask for a written response, file a written grievance, or your complaint is related to quality of care, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the CDPHP Medicare Grievance Process. To file a Grievance, you may call CDPHP member services at (518) 641-3950 or 1-888-248-6522 (TTY/TDD: 711). Or, if you wish, you may write to us at CDPHP, Attn: Medicare Appeals and Grievances, PO Box 66209, Albany, NY 12206 or fax it to (518) 641-3401. A member or his/her designated representative may file a Grievance with CDPHP either verbally or in writing.

Please note: If your complaint involves a behavioral health service or alcohol or substance abuse services, please call us at 1-888-320-9584.

A designated representative of CDPHP will coordinate the review and investigation of your Grievance. One or more qualified personnel will review the Grievance, provided that when the Grievance pertains to clinical matters, the personnel shall include, but not be limited to, one or more licensed, certified, or registered health care professionals. CDPHP will provide to you or your designee a written decision concerning the Grievance within 30 calendar days after receipt of the Grievance. If CDPHP cannot render a decision concerning your Grievance due to a lack of necessary information within 30 calendar days of receipt of your Grievance, a letter will be sent to you by the end of the 30th calendar day explaining the reason for the delay. CDPHP will make any such delayed decision and notify you of the decision within the next 14 calendar days with the case being reviewed on the information available.

You may file a fast or expedited grievance if you disagree with our decision to deny your request for a fast review of an initial determination or if we ask for an additional 14 days to process your initial determination or appeal request. You will receive information on how to file a fast or expedited grievance in your initial determination letter or in the letter we send informing you of the additional time we need to process your initial determination or appeal. You may file a fast or expedited grievance by calling CDPHP at (518) 641-3950 or 1-888-248-6522 (TTY/TDD: 711). Or, if you wish, you may write to us at CDPHP, Attn: Medicare Appeals and Grievances, PO Box 66209, Albany, NY 12206 or fax it to (518) 641-3401. We will make our decision within 24 hours after receiving your request.

The grievance must be submitted within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.

In certain cases, you have the right to ask for a “fast grievance,” meaning we will answer your grievance within 24 hours. For a detailed description of fast grievances, please call CDPHP and ask for the *Evidence of Coverage*.

You may complain about the quality of care received under Medicare, including care during a hospital stay. You may complain to us using the grievance process, to the Quality Improvement Organization (QIO), or both. If you file with the QIO, we must help the QIO resolve the complaint. The QIO for New York is Livanta. You may contact Livanta at: 9090 Junction Drive, Suite 10, Annapolis Junction, MD 20701, or by calling 1-866-815-5440. TTY users may call 1-866-868-2289. For a detailed description of the QIO grievance process, please call CDPHP and ask for the *Evidence of Coverage*.

Where to Learn More

You may request the aggregate number of grievances, appeals, and exceptions filed with CDPHP by contacting our member services department at the numbers listed above.

Capital District Physicians' Health Plan, Inc.
CDPHP Universal Benefits,® Inc.
6 Wellness Way
Latham, New York 12110
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