Attachment 2: LCI Appeals & Grievance Policy

Appeal and Grievance System Policy	
Affected LCI Units: Care Management, Quality, Provider Relations and Contracting	**Developed Date:** November 2016
Policy Number: MSUP0002	**Last LCI Review Date:** March 2022
Last DHS Approval: May 2022	**Policy Owner:** Quality
Authorization & Date: 11/2/16	

Purpose:

This policy defines the processes available to Lakeland Care, Inc. (LCI) members or a member's representative to file an appeal or grievance.

Scope:

All LCI members/legal representatives, their natural supports, LCI staff, and contracted providers.

Definitions:

Adverse Benefit Determination:

1. The denial of functional eligibility under Wis. Stat. § 46.286(1)(a) as a result of LCI's administration of the Long Term Care Functional Screen, including a change from Nursing Home (NH) Level of Care (LOC) to Non-Nursing Home (NNH) LOC.
2. The denial or limited authorization of a requested service that falls within the benefit package including the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit.
3. The reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount of time or duration and that amount, or duration has been completed.
4. The denial, in whole or in part, of payment for a service that falls within the benefit package.
5. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.
6. The denial of a member's request to obtain services outside LCI's network, when the member is a resident of a rural area with only one manage care entity.
7. The failure to provide services and support items included in the member's Member Centered Plan (MCP) in a timely manner.
8. The development of an MCP that is unacceptable to the member because any of the following apply:
    a. The plan is contrary to a member's wishes insofar as it requires the member to live in a place that is unacceptable to the member.
    b. The plan does not provide sufficient care, treatment or support to meet the member's needs and support the member's identified outcomes.
    c. The plan requires the member to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the member.
9. The involuntary disenrollment of the member from LCI at LCI's request.

10. The failure of LCI to act within the timeframes of this policy and procedure for resolution of grievances and appeals.

An "adverse benefit determination" is not:

1. A change in non-residential provider;
2. A change in the rate LCI pays a provider;
3. A termination of a service that was authorized for a limited number of units of service or duration of a service.
4. An adverse benefit determination that is the result of a change in state or federal law; however, a member does have the right to a State Fair Hearing in regard to whether he/she is a member of the group impacted by the change.
5. The denial of authorization or payment for a service or item that is not inside of the benefit package.
6. A denial, in whole or part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" under 42 CFR § 447.45(b).
7. The denial of authorization for remote delivery of a waiver service or a state plan service delivered via interactive telehealth.
8. The denial of a member's request to self-direct a service or the limitation of a member's existing level of self-direction.

Appeal: A request for LCI review of an "adverse benefit determination." If a member is dissatisfied with LCI's appeal decision, he or she can request a State Fair Hearing.

Appeal and Grievance System: The term "Appeal and Grievance System" refers to the overall system LCI implements to handle appeals of adverse benefit determinations and grievances, as well as the processes to collect and track information about them.

Case File: All documents, records and other information relevant to LCI's adverse benefit determination and the member's appeal of that adverse benefit determination. This includes, but is not limited to, medical necessity criteria, functional screen results, and processes, strategies, or evidentiary standards used by LCI in setting coverage limits and any new or additional evidence considered, relied upon, or generated by LCI (or at the direction of the LCI) in connection with the appeal of the adverse benefit determination.

Grievance: An expression of a member's dissatisfaction about any matter other than an "adverse benefit determination." When a member expresses dissatisfaction about any matter other than an adverse benefit determination, the member is expressing a grievance. If a member is dissatisfied with LCI's grievance decision, he or she can request a Department Review of the decision.

LCI Appeal & Grievance Committee: A regionally based five-member committee which has been designated by LCI's Board of Directors to hear appeals and grievances on behalf of LCI.

State Fair Hearing: Means a de novo review under Ch. HA 3, Wis. Admin. Code, before an impartial administrative law judge of an action by the Department, a county agency, a resource center, or an MCO.

Policy:

General Requirements

1. Members have the right to file an appeal regarding the adverse benefit determinations defined above, and have the right to grieve an action or inaction of LCI that the member perceives as negatively impacting them.

2. The IDT staff are the first level of support when a member is dissatisfied. Unless contrary to the expressed desire of the member, the IDT will attempt to resolve the issue through internal review, negotiation, or mediation if possible. If the IDT cannot resolve the issue it will refer the member to the Member Rights Specialist (MRS) or offer assistance to the member or legal decision maker who wishes to file a grievance or appeal.
3. LCI has designated the MRS as responsible to assist members when they are dissatisfied. The MRS will offer assistance to members in submitting appeals and grievances. The MRS assigned to assist a member in a specific circumstance may be responsible for scheduling and facilitating meetings but may not be a member of the LCI Appeal and Grievance Committee that considers the specific circumstance. The MRS may not represent LCI at any hearing level. The MRS will:
    a. Assist members and legal decision makers to understand the appeal or grievance options;
    b. Help the member and legal decision maker to complete any required paperwork to file the appeal or grievance; and
4. At the same time, unless contrary to the expressed desire of the member, the MRS and IDT staff will attempt to resolve issues through internal review, negotiation, or mediation. LCI upholds a member's right to have access to a fair, equitable, and confidential appeal and grievance system throughout their enrollment with LCI. LCI will not retaliate against members, providers, or other advocates acting on the member's behalf as a result of filing an appeal or grievance.
5. LCI's Board of Directors has delegated the responsibility to review and resolve appeals and grievances to LCI's Appeal and Grievance Committee.
6. All newly enrolled members will be oriented to the appeal and grievance process within 60 days of enrollment in a way that is understandable to the member or the member's representative. The orientation will include review of the section on appeals and grievances within the LCI Member Handbook.
7. IDT staff will review the appeal and grievance procedures with members and/or the member's representative annually during MCP reviews.
8. All newly hired and existing LCI staff will receive training on the appeal and grievance systems and their role in the system. Training on this policy and procedure is included in the new employee orientation.
9. A member, member's legal representative, or anyone acting on the member's behalf with written permission (including a provider, significant other, or professional advocate) may file an appeal or grievance with LCI, request a Department review, or file a State Fair Hearing.
10. Members may not file an appeal with LCI and a State Fair Hearing at the same time.
11. Members are encouraged to attempt to informally resolve their issues before filing a grievance or appeal.
    a. The member's IDT staff is usually in the best position to deal with issues directly and expeditiously. The MRS at LCI is the next most direct source of information at assistance.
    b. When a concern cannot be resolved through internal review, negotiation, or mediation with assistance of these individuals, LCI's Appeal and Grievance Procedure is the next step for resolving differences.
    c. Department Review is the final process in resolving member grievances.
    d. The State Fair Hearing process is the final administrative review process for resolving members' appeals of adverse benefit determinations.
    e. Other remedies may be available to members, depending on the circumstances and/or issues.
12. LCI will provide reasonable assistance to members with all aspects of completing and filing necessary forms and taking other procedural steps, such as: assistance with completing an oral grievance or appeal to writing, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. LCI is responsible for the cost of interpreters when a member is utilizing the Appeal and Grievance system.

13. LCI will attempt to mediate or negotiate all appeals or grievances prior to the hearing or review.
14. The member and his/her representative or the legal representative of a deceased member's estate, the Department, and LCI will be considered parties to the appeal.
15. *One Level of Appeal*
    LCI will only have one level of appeal and the member must exhaust this level of appeal before he or she can request a State Fair Hearing.

16. *Opportunity to Present Evidence*
    A member shall have a reasonable opportunity, in person and in writing, to present evidence, testimony, and legal and factual arguments, in an MCO grievance, MCO appeal, or State Fair Hearing. In an expedited review, the MCO must inform the member sufficiently in advance of the expedited appeal resolution timeframe of the limited time available to present evidence and testimony and make legal and factual arguments.

17. *Provision of Case File*
    LCI will ensure the member is aware they have the right to access their Case File, free of charge, and to be provided with a free copy of their Case File. The Case File must be provided to the member sufficiently in advance of the appeal resolution timeframes.
18. *Cooperation with Advocates*
    Members can involve any person of their choosing (including significant others, natural supports, providers, or any other advocates of the member's choosing) when engaging in the appeal and grievance process. LCI will make reasonable efforts to cooperate with all persons chosen by the member to assist with their appeal or grievance. A list of available resources for advocacy is included in the Member Handbook. Unauthorized release of member information is not allowed.

    a. As used here, "advocate" means an individual whom or organization that a member has chosen to assist in articulating his or her preferences, needs, and decisions.
    b. Cooperate means:
        i. To provide any information related to the member's eligibility, entitlement, cost sharing, care planning, care management services, or service providers to the extent that the information is pertinent to matters in which the member has requested the advocate's assistance.
        ii. To assure that a member who requests assistance from an advocate is not subject to any form of retribution for doing so.
19. *Information for providers*
    LCI's Service Provider Contract outlines LCI's policy and procedure related to appeals and grievances. All contracted LCI service providers:
    a. Shall agree to forward records to LCI related to member appeals and grievances within 15 business days of the request, or immediately if the appeal or grievance is expedited.
    b. Must recognize that members have the right to file appeals and grievances and will assure that such adverse benefit determinations will not adversely impact the way care is delivered.
    c. Will cooperate and not interfere with a member's appeals or grievances.
20. *Continuation of Benefits While an MCO Appeal or State Fair Hearing are Pending*
    a. Services will be continued by LCI throughout the local appeal process and State Fair Hearing process in relation to the initial adverse benefit determination if all of the following criteria are met:
        i. The member files the request for appeal timely
        ii. The appeal involves the termination, suspension, or reduction of previously authorized services;
        iii. The period covered by the original authorization has not expired;

iv. The member makes a timely request (submitted on or before the effective date in the NOA or LCI appeal decision) for continuation of benefit. If the request is timely, LCI must continue the benefits even if a previously authorized time period or service limit is reached during the course of the appeal process.

b. If, at the member's request, LCI continues or reinstates the member's services while the appeal or State Fair hearing is pending, the services must be continued until one of the following occurs:
    i. The member elects to withdraw the appeal or request for State Fair Hearing;
    ii. The member fails to request a State Fair Hearing and continuation of benefits within ten (10) calendar days after LCI sends the notice of adverse resolution to the member's appeal. In this context, sends, means putting a hard copy notice in the mail or transmitting the notice to the member electronically. If sending electronically, reference LCI Electronic Communication of Protected Health Information and Member Materials Policy and Procedure.
    iii. A State Fair Hearing decision is issued upholding LCI's reduction, suspension, or termination of services.
c. Member does not have a right to continuation of benefits:
    i. When grieving a change in provider that is the result of a change in LCI's provider network due to contracting changes; however, in such a situation the member does have the right to appeal on the basis of dissatisfaction with his/her MCP.
    ii. When grieving adverse benefit determinations that are a result of a change in state or federal law; however, in such a situation, the member has the right to appeal whether he/she is a member of the group impacted by the change.
d. If the final resolution of the appeal or State Fair Hearing is adverse to the member (i.e. upholds LCI's adverse benefit determination), LCI will not recover costs of services that have been continued.

21. *Reversed Appeal Decisions:* If the LCI appeal, or State Fair Hearing processes reverse a decision to deny, limit, or delay services that were not furnished during the appeal, LCI must authorize or provide the services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the decision. If LCI appeal, or State Fair Hearing processes reverses a decision to deny authorization of services, and the member received the disputed services during the appeal, LCI must pay for those services.

LCI Appeal and Grievance Committee

A regionally based five-member Appeal and Grievance Committee hears appeals and grievances on behalf of LCI. Appeal and Grievance Committee members cannot be members of the Board of Directors and will be free of conflicts of interest in the case. The Appeal and Grievance Committee members may not have been involved in any previous level of review or decision-making process related to that appeal or grievance, nor be a subordinate of an individual who was involved in a previous level of review or decision making.

LCI Appeal and Grievance Committee Members will be trained in the Appeal and Grievance Policy and Procedure; Confidentiality (including Health Insurance Portability and Accountability Act); Resource Allocation Decision (RAD) process; Family Care Principles; Care Management; Service Authorization; the Family Care Benefit Package; and Adverse Benefit Determination processes. The Committee will be trained at the following intervals: upon becoming a member of the Appeal and Grievance Committee and prior to participation in the first hearing, with major contract or policy changes that significantly impact decision making, and at least every three years. Each Committee member will agree to respect the privacy of LCI members.

The LCI Appeal and Grievance Committee shall make its determinations related to authorization of services based on whether services are necessary to support the member's Long-Term Care Outcome(s). The LCI Appeal and Grievance Committee shall take into account all comments, documents, records and other information submitted by the member or the member's legal representative without regard to whether such information was submitted or considered by the original adverse benefit determination.

The LCI Appeal and Grievance Committee will not review and make decisions on adverse benefit determinations related to:

1. Financial eligibility; or
2. Cost share calculations.

When making decisions related to an appeal of an adverse benefit determination that is based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, or an appeal or grievance that involves clinical issues, the Appeal and Grievance Committee will include healthcare professionals possessing the appropriate clinical expertise in treating and supporting the member's condition or disease. Each regional committee will be comprised of the following representatives:

1. Quality Specialist (QS): Two Quality Specialists will serve on the committee for each hearing whenever possible; selection of the specific Quality Specialists will be dependent on the location of the hearing and the need for a healthcare professional possessing clinical expertise in the member's condition or disease.
2. LCI Employee: One LCI employee from the Business Division and/or Provider Relations and Contracting Division.
3. Member Representative: One member, or legal representative, or individual, or legal representative of that individual, eligible to receive Family Care benefits. The member filing the appeal will be offered the choice to exclude any member representative from participation in a hearing on a matter brought before the LCI Appeal and Grievance Committee.
4. Community Representative: One community representative who has an interest in supporting the target groups served by LCI; some of these individuals are healthcare professionals possessing clinical expertise in the member's condition or disease and will be selected when indicated.

Notification of Appeal Rights in Other Situations

On the date LCI becomes aware of the following situations, written notification of appeal rights will be issued:

1. *Change in Level of Care from Nursing Home (NH) to Non-Nursing Home (NNH):* LCI will mail or hand deliver the Department Notice of Change in Level of Care form which includes written notification of appeal rights when LCI administers a LTCFS that results in a reduction of the member's LOC from NH to NNH. Members whose LOC changes from NH to NNH must receive a written notice that clearly explains the potential impact of the change; the member's right to request a functional eligibility re-screening, the member's right to appeal with LCI, and the member's right to request a State Fair Hearing following LCI appeal decision or failure to issue a decision within the appropriate timeframes. LCI shall provide for functional eligibility re-screening by a different screener within ten (10) calendar days of a request by a member or member's legal decision maker. The notice must be mailed or hand-delivered to the member on the date the screen is calculated and an effective date of not less than fifteen (15) calendar days from the date the screen is calculated.
    a. LCI does not provide notification to the member of a change in level of care when the member is found to no longer meet any level of care because the ForwardHealth interChange system will automatically issue a Notice of Loss of Functional Eligibility to

the member which includes an explanation of the member's appeal rights. LCI will continue to provide services until the date of disenrollment.

b. If the member remains enrolled at the non-nursing home level of care and LCI will reduce or terminate any service as a result of the change in level of care, LCI must provide an additional notice of adverse benefit determination.

2. *Adverse LCI Grievance Decision*: LCI must mail or hand-deliver a written decision regarding a grievance to the member and the member's legal decision maker, if applicable, within ninety (90) calendar days after the receipt of the grievance. When LCI's decision is entirely or partially adverse to the member, the decision must include the reason for the decision and the member's right to request DHS Review of the LCI's grievance decision. LCI will use Department mandated templates.
3. *Adverse LCI Appeal Decision*: LCI must mail or hand-deliver a written decision regarding an appeal to the member and the member's legal decision maker, if applicable, within thirty (30) calendar days after the receipt of the appeal. When the LCI's decision is entirely or partially adverse to the member, the decision must include notice of the member's right to request a State Fair Hearing. The notification shall establish the effective date of the implementation of the decision not less than fifteen (15) calendar days from the date of the notification. LCI will use Department mandated templates.
4. *Involuntary Disenrollment of the Member from LCI at LCI's request*: all requested disenrollments must be approved by the Department and when the Department approves the request, the ForwardHealth interChange system will automatically issue a Notice of Disenrollment to the member which includes an explanation of the member's appeal rights.
5. *Other Adverse Benefit Determinations*: a member has the right to appeal other adverse benefit determinations defined in this policy. On the date LCI becomes aware of any such adverse benefit determination, the LCI will mail or hand deliver the written notification of the right to appeal these adverse benefit determinations with LCI and the right to request a State Fair Hearing following LCI's appeal decision or LCI's failure to issue a decision within the appropriate timeframes.

Documentation and Monitoring of the Appeal and Grievance System

1. LCI shall maintain a log of member appeals and grievances.
2. Quarterly, LCI shall submit to the Department a report consisting of an appeal and grievance summary and a log using parameters issued by the Department.
3. LCI will retain the documents related to each appeal or grievance in accordance with LCI's policies and procedures.
4. Quarterly, the Appeal and Grievance summary will be presented to LCI's Board of Directors.
5. The Quarterly Appeal and Grievance summary and log will be reviewed by LCI's Quality Committee to identify potential trends and opportunities for improvement throughout LCI and its contracted providers.

Reference:

Department of Health Services, Division of Long Term Care, Family Care Contract