

Appeals, Grievances, and Complaints: Identification and Processing

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Presentation Overview

Today's presentation will cover:

- Appropriate classification of Part C and D requests for coverage or appeals, grievances, and complaints
- Effects of misclassification
 - Delayed or denied access to the drug/service
 - Delayed access to coverage and/or appeals process
- Appropriate handling of CTM complaints

Current CMS Requirements

- A complaint may contain a grievance, request for coverage or appeal, or both.
- All issues must be reviewed by plans on a case-by-case basis to determine how they should be categorized and processed.
- If the facts do not clearly indicate that the complaint is a grievance, the plan should process as an appealable issue (i.e. a coverage request).

Coverage Requests and Appeals

A **coverage request** is a request for a coverage determination or an organization determination from an enrollee, their representative, prescriber, or provider for payment or provision of an item, service, or drug.

If an enrollee disagrees with a coverage or payment decision, they can appeal that decision. An enrollee can appeal a Medicare health plan or Part D plan sponsor's denial for:

- Request for a health care service, supply, item, or prescription drug.
- Request for payment of a health care service, supply, item, or prescription drug already received.
- Request to change the amount the enrollee was required to pay for a health care service, supply, item, or drug.

Coverage Requests

Examples of coverage requests:

- The enrollee calls the plan and says, “My pharmacy said you won’t pay for drug X, but I need it.”
- Enrollee calls requesting a drug
- Enrollee calls and argues that a drug is not excluded from Part D coverage for the indication for which it is being prescribed
- Enrollee calls and is upset because his/her specialist is no longer contracted with the plan and wants to continue care with the provider (out of network coverage)
- Dispute over the cost-sharing

Appeals

- An enrollee calls and says, “I want to file a complaint. You denied my request for drug X or service Y and I need it.” When a coverage determination or organization determination has been made, the enrollee’s dispute should be treated as an appeal of the denial. Therefore, either an appeal should be started, or if the health plan or plan sponsor does not accept oral standard appeals, they must inform the enrollee of how to submit a written appeal request.

Polling Question # 1

An enrollee calls the plan and says he/she is upset because the pharmacy would not fill his/her prescription because it requires a prior authorization.

How should this complaint be categorized?

- a. Coverage Request
- b. Grievance
- c. Appeal

Polling Question # 2

An enrollee calls and says, “You denied my request for home health, but I need it because I cannot leave my home.”

How should the plan classify this complaint?

- a. Coverage Request
- b. Grievance
- c. Appeal

Grievances

A grievance is any complaint or dispute brought by an enrollee or their representative that is not a request for coverage.

- There are no appeal rights associated with a grievance.
- Generally, a longer timeframe to notify enrollee or representative of the resolution.

COMPLAINT

TO:	NAME	DATE	TIME
WHOSE FAULT:	NONE	OTHER	OTHER
DESIRED OUTCOME:	APOLGY	LITIGATION	RESTITUTION
	EXPLANATION	PROMOTION	CHANGE
COMPLAINANT:			
<input type="checkbox"/> ANONYMOUS			

Grievances (cont.)

Examples of grievances may include complaints concerning:

- An enrollee's involuntary disenrollment initiated by the plan
- A change in premiums or cost sharing arrangements from one contract year to the next
- Difficulty contacting plan via phone
- Interpersonal aspects of care
- The appeals process
- Plan's denial of expedited coverage or appeal request
- An expression of general dissatisfaction about a co-payment amount, but is not disputing the amount he or she paid

Polling Question # 3

A plan has received a complaint from a enrollee about a change in his/her premium. Within what time frame should the plan respond to the complaint?

- a. 7 calendar days
- b. 14 calendar days
- c. 30 calendar days

Grievance and Coverage Requests

- Multiple complaints can be discussed in the same phone call or in a letter. If an enrollee raises two or more issues, each issue should be processed separately and simultaneously (to the extent possible) under the appropriate procedure.



Polling Question # 4

A member sends a letter complaining that he/she had to wait so long for a service or Part D benefit that he/she went out of network. How should this request be treated?

- a. Coverage Request
- b. Grievance
- c. Both

Grievance and Coverage Requests (cont.)

- An enrollee has a benefit that covers one pair of eyeglasses every 24 months with a maximum contribution of \$70.00. The enrollee asserts that the glasses are no good and the prescription was wrong. The enrollee requests that the plan cover another pair of glasses. Where an enrollee complains that the previously rendered services are inadequate and substandard in quality, this would be classified as a grievance (quality of care complaint), and the request for a new pair of glasses is a new coverage request.

Effects of Misclassifying the Request

- Delayed or denied access to the drug/service
- Delayed access to the coverage and/or appeals process



Procedures For Handling Misclassified Cases

Coverage Requests that are misclassified as Grievances

Upon discovery the plan should:

- Immediately forward the request to the appropriate division for processing.
- Notify the enrollee in writing that the request was misclassified and will be handled through the appeals process.

Grievances that are misclassified as Coverage Requests

If the plan issues a denial notice and the case goes to the IRE:

- The IRE will dismiss the appeal and return the case to the plan for proper processing.
- The plan must notify the enrollee in writing that the complaint was misclassified and will be handled through the plan's grievance process.

Best Practices

- Ensure that staff/customer service representatives, including staff at delegated entities, are trained to distinguish between coverage requests and grievances and are equipped to process those requests.
- Complete the available CMS Web Based Training.
- Utilize CMS Account Managers as a resource.

In Summary

- Plans are expected to audit their own coverage determination, appeals, and grievance systems for the presence of errors and to implement appropriate quality improvement processes as needed.
- Plans must determine whether the complaint is a request for coverage, a grievance, or both. Complaints must be categorized on a case-by-case basis as determined by the facts and circumstances of each request.

Contacts

- For questions about Part C organization determinations, appeals, and grievances contact:
Part_C_Appeals@cms.hhs.gov
Part_C_Appeal@cms.hhs.gov
- For questions about Part D coverage determinations, appeals, and grievances contact:
PartD_Appeals@cms.hhs.gov
PartD_Appeals@cms.hhs.gov

Complaints – Definition

- Part C, Part D, PACE, Cost Plan, and/or MMP issues that require investigation and/or action on the part of CMS, a plan, or the Medicare Drug Integrity Contractor (MEDIC) at the request of a beneficiary, partner, or other stakeholder, often (but not always) after they have first sought resolution with a plan.
- Complaints may relate to, but are not limited to: costs, enrollment, access to care, marketing, or customer service.
- All complaints are tracked and managed in HPMS' Complaints Tracking Module (CTM) for monitoring of the resolution.

Complaints – CTM

- Implemented in 2006, CTM is a secure module in HPMS.
- Used by CMS to manage and monitor casework resolution, as well as plan compliance.
- Plans are expected to review their CTM complaints regularly, resolve issues timely, and engage with CMS on matters outside their control to resolve.
- All complaints are concurrently assigned to a CMS caseworker, and most of a parent organization's complaints are overseen by one of CMS' ten regional offices.
- Redesigned in March 2017 to improve data collection and reduce burdens.

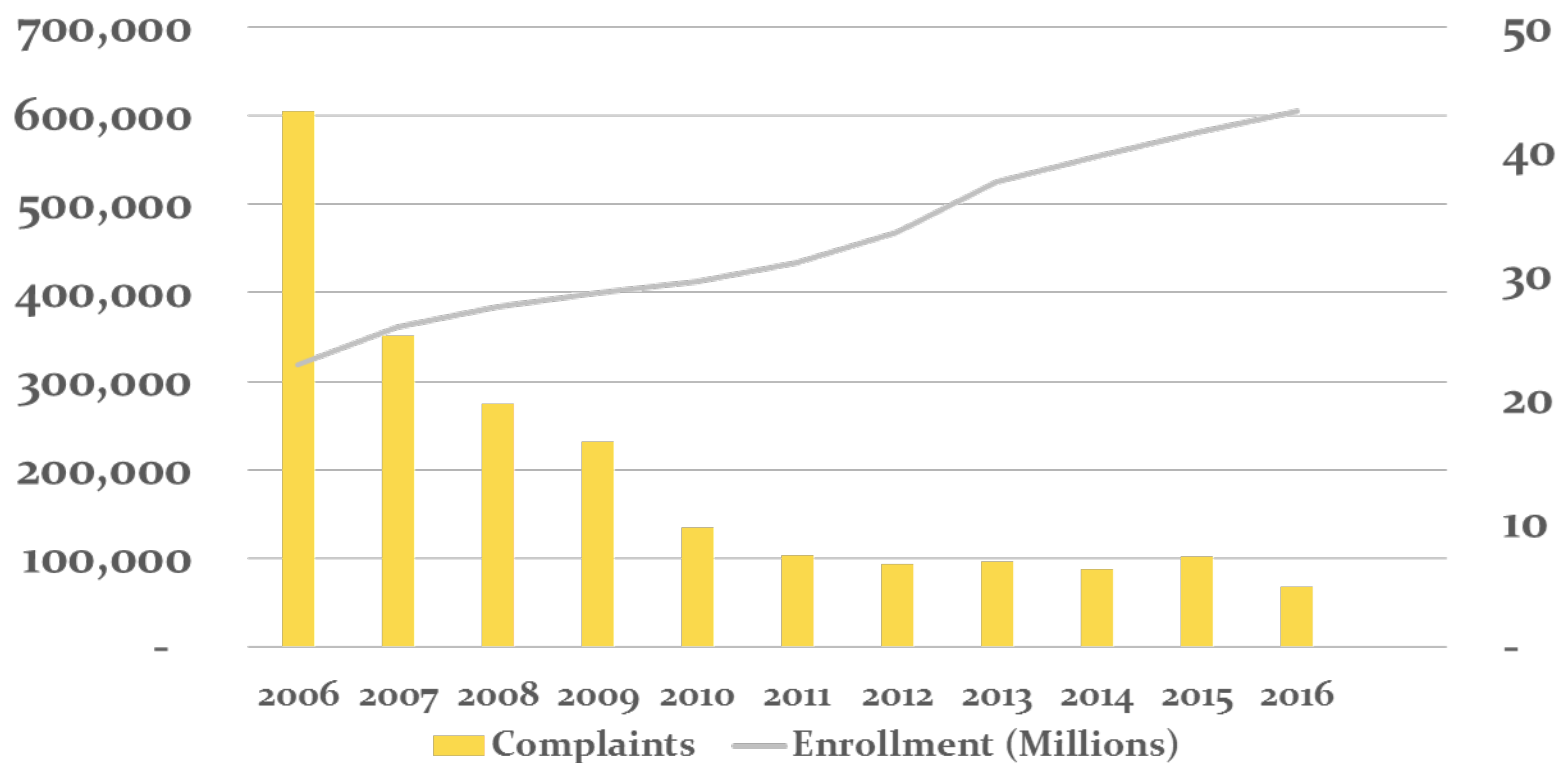
Complaints – Sources (2016)

- CTM complaints are received through multiple sources:
 - 1-800 MEDICARE - 71%
 - CMS Direct - 22%
 - State Health Insurance Programs (SHIP) - 3%
 - Medicare Drug Integrity Contractors (MEDIC) - 2%
 - Other - 2%
- Resolutions recorded by:
 - 737 Plan Contracts
 - CMS Staff
 - MEDIC

Complaints – Types (2016)

- Complaints are categorized to assist CMS with issues monitoring and trend analysis.
- Top categories:
 - Enrollment/Disenrollment - 34%
 - Pricing/Premium/Co-Insurance -16%
 - Marketing - 13%
 - Benefits/Access - 11%
 - Customer Service - 7%

Complaints – Annual Trend



Complaints – Polling Question # 5

Typically, plan complaints are recorded in the Complaints Tracking Module (CTM) only after a beneficiary or provider has first sought resolution with the plan. True or False?

- a. True
- b. False

Complaints – Compliance

Standards:

- Immediate Need – 95% resolved within 2 calendar days
- Urgent – 95% resolved within 7 calendar days
- No Issue Level – 95% resolved within 30 calendar days



Complaints – Handling Best Practices

- Triage
- Contact the complainant promptly to acknowledge issue and/or gather additional information
- View attachments and include supporting documentation
- Enter interim casework notes
- Notify complainant of resolution and enter quality resolution notes
- Encourage the individual to follow-up with the plan with further questions or new issues

Complaints – Best Practices

- Proactively engage in efforts designed to reduce the likelihood of CTM complaints, including root-cause analysis.
- Discuss issues early and often with your Account Manager and/or CMS Lead Caseworker.
- Ensure that plan call center staff are adequately trained and do not refer beneficiaries to 1-800-MEDICARE with matters within the plan's control to resolve.
- Utilize the SHIP Unique ID listing to provide SHIPs with expedited service and prevent complaints.
- Assure adequate staffing for annual peak complaint period, after the end of Open Enrollment.

Complaints – Additional Resources

- HPMS Memorandum
 - December 16, 2016 - Introducing the CTM Redesign.
 - Includes Plan Complaint Download File Layout and Plan Casework Upload File Layout.
 - February 17, 2017 - New Best Available Evidence (BAE) Assistance Process
 - Explains the steps associated with entering BAE assistance requests cases into CTM for CMS handling. Replaced August 2008 HPMS memo.
 - February 24, 2017 - CTM Plan SOP
 - Replaced the December 2015 Plan SOP and all previous CTM guidance.
- CTM Plan User Guide
 - Located in the CTM Documentation section.

Questions?

