Health Plan Policy
Medicare Policies

Medicare Part C and D Grievance Policy

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<th>Policy Number:</th>
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PURPOSE:

EXPLANATION:

Kaiser Permanente Health Plan of Washington (KPWA) has Medicare Advantage (MA) and Medicare Advantage Part D (MA-PD) contracts with the Centers for Medicare and Medicaid Services (CMS) to provide Medicare and Medicare Part D benefits to Kaiser Permanente Health Plan of Washington MA and MA-PD members. Under the terms of the contracts, Kaiser Permanente Health Plan of Washington is required to have Grievance procedures for members that adhere to all processing standards and timeframes set by CMS. This document outlines the Kaiser Permanente Health Plan of Washington Medicare Advantage (MA) and Medicare Advantage Part D (MA-PD) standard grievance procedures related to scope, applicability, exceptions and guidelines.

A Medicare Advantage grievance is any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which an MA organization or delegated entity provides health care services, regardless of whether any remedial action can be taken. A member may make the complaint or dispute, either orally or in writing no later than 60 days after the event, to an MA organization, provider, or facility. An expedited grievance may also include a complaint that an MA organization refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration timeframe.

In addition, MA grievances may include complaints regarding timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during the course of treatment did not meet accepted standards for delivery of health care.

A Medicare Advantage Part D grievance is any complaint or dispute, other than a coverage determination or an LEP determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Part D plan sponsor, regardless of whether remedial action is requested. A grievance may also include a complaint that a Part D plan sponsor refused to expedite a coverage determination or redetermination. Grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided item.

If a member is not disputing that a drug is not a covered Part D drug (as defined in 1860D-2(e)(1) of the Act) or is excluded under 1860D-2(e)(2) or 1860D-43 of the Act, but he/she is complaining about the policy that causes the drug to be excluded or not a covered Part D drug, the complaint will be processed as a grievance because it is a complaint about Kaiser Permanente Health Plan of Washington's benefit design structure. This complaint may occur after an inquiry is made, or it may be the initial transaction with the member, physician, or other prescriber. Decisions made under Kaiser Permanente Health Plan of Washington's grievance process are not subject to appeal.
**POLICY:**

As a Medicare Advantage contractor, Kaiser Permanente Health Plan of Washington acts as the Medicare Part C carrier for Kaiser Permanente Health Plan of Washington and Kaiser Permanente Health Plan of Washington Options members and therefore is responsible for administering and providing clinical and services to Medicare members per their specific Medicare Benefit Coverage Plan.

As a Medicare Advantage Part D contractor, Kaiser Permanente Health Plan of Washington acts as the Medicare Part D carrier for Kaiser Permanente Health Plan of Washington and Kaiser Permanente Health Plan of Washington Options members and therefore is responsible for administering and providing clinical and prescription drug services to Medicare Part D members per their specific Medicare Drug Benefit Coverage Plan.

Grievances are handled within the Health Plan, through the health plan’s internal complaint and appeal process. Kaiser Permanente Health Plan of Washington processes Medicare Part C and Medicare Part D member grievance requests and consults with Medicare Administration when appropriate, to determine the best resolution to the member’s complaint. Grievances are not sent to CMS for their determination. All Medicare grievances follow CMS criteria as established in the Medicare Managed Care Manual, Chapter 13 and the Prescription Drug Benefit Manual, Chapter 18.

This policy was established to address the grievance processing requirements defined in the Chapter 13 Medicare Managed Care Manual Guidelines, Medicare Managed Care Beneficiary Grievances, Organization Determinations and Appeals and in Chapter 18 of the Prescription Drug Benefit Manual, Part D Member Grievances, Coverage Determinations and Appeals.

Kaiser Permanente Health Plan of Washington ensures that Medicare Advantage and Medicare Advantage Part D members have the following rights:

- The right to have grievances heard and resolved in accordance with the guidelines that are described in Chapter 13 of the Medicare Managed Care Manual and Chapter 18 of the Prescription Drug Benefit manual
- The right to request quality of care grievance data from Kaiser Permanente Health Plan of Washington
- The right to make a quality of care complaint under the QIO process.

**DESCRIPTION:**

1. Kaiser Permanente Health Plan of Washington staff is trained to distinguish correctly between organization determinations, coverage determinations, reconsiderations, redeterminations and grievances and process them through the appropriate mechanisms. Routine monitoring is carried out to ensure cases are categorized correctly and meet requirements. (GV-01)

2. Kaiser Permanente Health Plan of Washington notifies the member of its decision as expeditiously as the grievance case requires based on the member’s health status but no later than 30 days after the receipt date of the oral or written grievance. If the complaint involves a Kaiser Permanente Health Plan of Washington decision to invoke an extension relating to an organization determination or reconsideration, or the complaint involves a Kaiser Permanente Health Plan of Washington refusal to grant an member’s request for an expedited organization determination or expedited reconsideration, Kaiser Permanente Health Plan of Washington responds to an member’s grievance within 24 hours. If the member requests an extension, or if Kaiser Permanente Health Plan of Washington justifies a need for information and documents that the delay is in the interest of the member, Kaiser Permanente Health Plan of Washington may extend the 30-day timeframe up to an additional 14 days. In this case, Kaiser Permanente Health Plan of Washington must immediately notify the member in writing of the reasons for the delay (GV-02)

3. Kaiser Permanente Health Plan of Washington notifies the member of the disposition of the grievance. For quality of care issues, Kaiser Permanente Health Plan of Washington also includes a description of the member’s right to file a written complaint with the QIO. (GV-03)

4. Kaiser Permanente Health Plan of Washington responds to written grievances in writing. Kaiser Permanente Health Plan of Washington responds to oral grievances either orally or in writing, unless the
member requests a written response in which a written response will be provided. Kaiser Permanente Health Plan of Washington responds to all grievances related to quality of care in writing, regardless of how the grievance was submitted. (GV-04)

5. Kaiser Permanente Health Plan of Washington has established and maintains policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written member grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. Kaiser Permanente Health Plan of Washington maintains records of such grievances. (GV-05)

6. Kaiser Permanente Health Plan of Washington responds in writing to all grievances related to the quality of care. The response includes a description of the member’s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, Kaiser Permanente Health Plan of Washington cooperates with the QIO in resolving the complaint. (GV-06)

7. Kaiser Permanente Health Plan of Washington responds to a member’s grievance within 24 hours if the complaint involves a refusal to grant a member’s request to expedite a coverage determination or redetermination, and the member has not yet purchased or received the drug that is in dispute. (GV-07)

APPLICABILITY:
This policy supports the requirements stated in this document and is approved for Kaiser Permanente Health Plan of Washington Cooperative (GHC) Medicare Advantage and Medicare Advantage Part D plans and has been adopted by Kaiser Permanente Health Plan of Washington Options, Inc. (GHO) for Medicare Advantage and Medicare Advantage Part D plans.

INTERNAL AUDIT PROCESS

Kaiser Permanente Health Plan of Washington complies with the CMS requirement for conducting internal audits and reporting internal audit results and findings as required by CMS. All Kaiser Permanente Health Plan of Washington operational areas with responsibility for ensuring compliance with CMS requirements must complete internal audits as directed by the Director of Medicare Programs and Compliance. Medicare Programs and Compliance reports internal audit results to CMS Regional office as required.

The Medicare Advantage compliance team conducts quarterly internal monitoring of CMS Medicare health plan grievance audit elements (Universal and Part D audit guides). The results from quarterly internal audits are reported to Kaiser Permanente Health Plan of Washington’s Medicare Advantage operations leadership team, to the Medicare Programs and Compliance Department, to organizational Compliance Oversight Committees, the Executive Leadership Team, and the Board of Directors as described in the GHC Global Medicare Advantage and Medicare Advantage Prescription Drug Internal Monitoring Oversight Policy MPC-049.

Grievance response timeliness is verified by review of daily and weekly aging reports that show all complaints that remain unresolved 20 days after filing. In the event that an member files multiple grievances during a reporting period the grievances are reviewed using the CMS Part C and Part D Reporting Requirements to ensure that any grievances considered duplicates (about the same issue) are excluded from the GHC/GHO Part C and Part D Grievance reporting.

Corrective Action

• Corrective actions are self-identified by operational departments, or identified by Medicare Programs and Compliance and are implemented by operational areas. Corrective Action Plans (CAP) implementation is initiated with oversight by Medicare Programs and Compliance.
• Operational area reporting frequency is weekly or monthly to Medicare Programs and Compliance.
• Medicare Programs and Compliance reports to CMS as required.

KPWA Medicare Advantage and Medicare Advantage Part D Compliance Program
All KPWA MA and MA-PD policies and procedures are reviewed and approved annually per the Kaiser Permanente Health Plan of Washington Medicare Advantage and Medicare Advantage Part D Compliance Program requirements.

SCOPE:

RESPONSIBILITIES:

Health Plan Operations Compliance is responsible for implementation and oversight of this policy.

DEFINITIONS:

Member: A member is a Medicare Advantage or Medicare Advantage Part D enrollee who has elected a Medicare Advantage or Medicare Advantage Part D plan offered by an MA or MA-PD organization, or a Medicare Advantage or Medicare Advantage Part D enrollee who has elected a cost plan or HCPP.

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 MA or MAPD 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 a member’s rights.
- Pharmacy Copays and the cost of medication.
- Refusal to expedite a coverage determination or appeal.
- Membership, enrollment, or dues issues.

Redetermination (Appeal)
Any of the procedures that deal with the review of adverse coverage determinations made by the MA or MA-PD plan sponsor on the benefits under a MA or MA-PD plan the member 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 member must pay drug coverage. These procedures include redetermination by the MA _MAPD 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 MA or MAPD plan sponsor or provider by a member made orally or in writing. This can include concerns about MA or MAPD plan sponsors or their contractors, such as; waiting times when you fill a 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 a member 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 MA or MAPD plan sponsor regarding payment or benefits to which a member believes he or she is entitled.

Quality of Care Issue
A Quality of care issue may be filed through the MA or MAPD 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 MA or MAPD 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:

Medicare Managed Care Manual Chapter 13 Section 20
Prescription Drug Benefit Manual Chapter 18 Section 20

Medicare Advantage Part C and D Grievances

Authorized Authority: Director, Health Plan Operations Fe’Lecia Boudy
Designated Content Expert: Manager, Benefits and Appeals, Ildiko Mircea

Related Policies, Documents and References:
MPC-049
Medicare Advantage Part C and D Grievances

Documents which refer to this document:

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