Integrated and Unified Member Grievances and Appeals

AmeriHealth Caritas
VIP Care

Integrated and Unified Member Grievances and Appeals Summary

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- The existing Medicare and Medicaid appeal processes require dually eligible individuals to navigate separate appeal pathways, depending on whether the benefit in question is covered by Medicare, Medicaid, or both.
- For example, even if an individual is enrolled in Medicare and Medicaid plans operated by the same parent company, these processes differ in certain respects, such as the timeframes in which a plan must make a decision about an enrollee's grievance.
- The integrated appeal process resolves these misalignments by creating a single grievance and appeal pathways at the plan level for all Medicare (other than Medicare Part D) and Medicaid benefits for enrollees in applicable integrated plans.

Member Grievance versus Complaints

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Complaints:

- If a member has a complaint regarding the quality of care, waiting times, customer service, etc. he/she has received, he/she should contact the Member Services department at the toll-free number on the back of their identification card.
- A Member Services representative will answer questions or concerns. The representative will try to resolve the problem. If the Member Service representative does not resolve the problem to the member's satisfaction, then the member has the right to file a grievance.

Grievances:

- A grievance expresses dissatisfaction about matters related to the services offered by AmeriHealth Caritas VIP Care.
- The member may file a grievance in writing or by phone at any time.
- It may be filed by the provider (or another authorized representative) on behalf of the member with the member's written consent.
- A grievance may be filed about such things as the quality of the care the member receives from an AmeriHealth Caritas VIP Care provider, rudeness from a plan or provider's employee, a lack of respect for their rights by AmeriHealth Caritas VIP Care or any service or item that did not meet accepted standards for health care during a course of treatment.

Member Appeals (Reconsiderations)

Following the receipt of an Adverse Benefit Determination notice, called the ***Coverage Decision Letter***, denying payment for a service, denying authorization of a service or discontinuing services the member is in the process of receiving:

- The member or the member's authorized representative (physician, family member or any other person who has received authorization) or a non-contracted provider may file a request for an appeal.
- The request may be filed in writing or verbally by contacting Member Services.
- The member or the member's representative may file two types of appeals:
  - ✓ Standard appeal
  - ✓ Expedited appeal
- A standard appeal can consist of appealing an action that denies payment for a service, denies authorization of a service, or discontinues services a member may be in the process of receiving.
- An expedited appeal may be an appeal that as a result of the action by AmeriHealth Caritas VIP Care, the member's health may be jeopardized if the standard appeal process is followed.

Appeal Timeframes

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Type of Appeal	Timeframes
Expedited Appeal	The applicable integrated plan must provide notice of its expedited integrated organization determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request.
Standard Appeal	The applicable integrated plan must resolve integrated reconsiderations as expeditiously as the enrollee's health condition requires but no later than 30 calendar days from the date of receipt of the request for the integrated reconsideration.
Extensions	The applicable integrated plan may extend the timeframe for a standard or expedited integrated organization determination by up to 14 calendar days if— (A) The enrollee or provider requests the extension; or (B) The applicable integrated plan can show that— (*1*) The extension is in the enrollee's interest; and (*2*) There is need for additional information and there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received.

Steps Following an Appeal

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- For expedited appeals, the Plan will make reasonable efforts to provide verbal notice to the member, member representative or member's provider of the appeal determination in addition to providing a written notice.
- For standard appeals, the Plan will send notice of the appeal determination through a written notice. The written notice provided to the member or member representative will detail the resolution, how the resolution was determined and next steps with respect to the resolution.
- For appeals not resolved wholly in favor of the members, the written resolution letter will include:
  - Information on how to file an External Appeal, also called a Level 2 Appeal. This appeal is reviewed by an independent organization that is not connected to the plan:
    - Medicare - Medicare Independent Review Entity (IRE)
    - Michigan Medicaid - Michigan Medicaid Fair Hearing with the Michigan Office of Administrative Hearings and Rules (MOAHR) or the Department of Insurance and Financial Services (DIFS)

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Coverage by AmeriHealth First.