ELDERPLAN, Inc.
POLICIES AND PROCEDURES

SECTION: EP-1100 Grievance and Appeals	SUBJECT: Member Appeal Rights for Medicaid Services	EFFECTIVE DATE: DRAFT	Page 1 of 9

I. Policy

Elderplan will act to insure that the appeal rights of all members are communicated to the involved parties and carried out by the Plan in accordance with all applicable Federal and State regulations. An appeal is defined as a request for a review of an action.

Elderplan members, member designees and health care providers will be knowledgeable regarding their rights to request an appeal, the proper timeline for such submissions, and time frame for processing of the request. The following actions by the Plan are grounds for a member, or their representative, to file an appeal:

- The denial, or limited authorization of a requested service, including the type or level of service.
- The reduction, suspension or termination of a previously authorized service during the authorized period.
- Decision that a requested service is not part of a covered benefit.
- Failure to provide services in a timely manner.
- Failure of the Plan to make a grievance or grievance appeal decision within the required timeframes.

Note: New York has elected to require that a member exhaust the plan's internal appeal process before an enrollee may request a State Fair Hearing.

Expedited Appeal – If Elderplan determines or the provider indicates that a delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function or the action was the result of a concurrent review of a service authorization request. A member may also request an expedited review of an appeal. If an expedited review is not requested, the appeal will be treated as a standard appeal.

Elderplan will designate one or more qualified personnel who were not involved in any previous level of review or decision-making to review the appeal, and if the appeal pertains to clinical matters, the personnel must include licensed, certified or registered health care professionals.

Elderplan may deny a request for an expedited review, but must make reasonable efforts to give oral notice of denial of an expedited review and send written notice within 2 calendar days

of the oral request. The appeal is then handled as a standard appeal. A member's disagreement with Elderplan's decision to handle the appeal as a standard appeal is considered a grievance – see Grievance Procedures.

An appeal may be filed orally or in writing. If filed orally, Elderplan will provide the member with a summary of the appeal in writing as part of the acknowledgement letter or separately. The date of the oral request for both standard and expedited appeals is treated as the date of the appeal.

II. Appeal – Expedited and Standard

1. An appeal must be requested within 45 days of the postmark date of the notice of action if there is no request for aid to continue or within 10 days of the notice's postmark date or of the intended date of the action if aid to continue is requested and the appeal involves the termination, suspension or reduction of a previously authorized service.

2. If aid to continue is requested, existing services will continue until the sooner of: a) appeal is withdrawn, b) the original authorization period has expired, or c) until 10 days after appeal decision is mailed, if the decision is not in the member's favor, unless a NYS Fair Hearing has been requested.

3. Elderplan must send written acknowledgement of an appeal within 15 days of receipt. If a decision is reached before the written acknowledgement is sent, the plan may include the written acknowledgement with the notice of decision as one notice.

4. An appeal must be decided as fast as member's condition requires, but:

    a. Expedited: within 2 business days of receipt of necessary information and no later than 3 business days after receipt of the expedited appeal request.

    b. Standard: no later than 30 calendar days after receipt of the appeal request.

5. Up to a 14 calendar day extension may be granted. An extension may be requested by the member or the provider on the member's behalf (written or verbal). Elderplan may also initiate an extension if it can justify the need for additional information and if the extension is in the member's interest. In all cases, the extension reason must be well-documented.

6. Elderplan must make a reasonable effort to give oral notice for expedited appeals and must send written notice within 2 business days of the decision for all appeals. If dissatisfied, members may file both a State Fair Hearing and an External Appeal. If both are filed, the State Fair Hearing decision is the one that counts.

III. PROCEDURE

Filing A Request for Appeal

1. If the member or member designee believes that an action is not correct, he or she can exercise the right to request an appeal by calling the Member Services Appeals and Grievances Coordinator at (800)353-3765 or by writing to: Elderplan Appeals and Grievances Department, 6323 Seventh Avenue, Brooklyn, NY 11220. The letter should detail why the member or member designee, believes the claim or service in question should be approved.

2. The request for appeal must be received within forty-five (45) days from the postmark date of the notice of action. If it does not the member will be sent a letter (see attachment XXX: "A3 – Appeal Denial Greater Than 45 Day Letter") explaining the denial.

3. The following individuals can file an appeal request:

    a) the member

    b) the member designee

    c) the health care provider (if designated as a representative by the member)

4. The member may designate someone to be their representative:

    a. A legal representative, upon completion of an assignment of representative statement or submission of proxy information.

    b. The member can designate a health care provider as his/her representative. Both the provider and the member must sign an Elderplan Privacy Release.

5. The Member Services Manager coordinates and arranges for the member or member designee to have access to the member's clinical file and ensures that the member or member designee has access to the information prior to the meeting of the Appeals Committee. The Appeals Committee will review the same information and provide a determination in writing to the Appeals Coordinator for inclusion in the Plan decision to the member.

6. Upon receipt of an appeal of a previously denied service the Appeals & Grievances Department will acknowledge the appeal in a letter (see attachment "A0 – Appeal Acknowledgment Letter) to the member within 15 days of receipt and a date will be set for the appeal to be heard by the Appeals Committee. The member is informed in the acknowledgment letter that they, or their representative, may attend the appeal meeting and present evidence concerning their request. The appeal must be decided as quickly as the member's condition warrants, but no later than 45 days from receipt of the appeal.

7. Up to a 14 calendar day extension is allowable. An extension may be requested by the member or by a provider on the member's behalf (written or verbal). Elderplan may also initiate an extension if it can justify the need for additional information and if the extension is in the member's best interest. If additional information is needed, a letter (see attachment "A1 – Appeal Ack Need Info Letter) will be sent to the member indicating any information necessary in deciding the appeal. In all cases, extensions must be well documented.

8. In the event that an expedited appeal is requested, the request is forwarded to the Associate Director of Clinical Services for determination as to whether the appeal meets the criteria for an expedited appeal. If it does, the appeal will be heard within 2 business days of receipt of necessary information and no later than 3 business days after receipt of the expedited appeal request. If it does not, the member will be informed of such (see attachment "D0 – Expedited Denial Letter") along with their Fair Hearing rights and the appeal will then be

handled as a standard appeal.

9. Upon reaching a decision by the Appeals Committee the member will be informed of the decision by letter.

Responsible Personnel for Appeals

1. The intake and coordination of appeals and grievances will be handled by the Appeals and Grievances Coordinator. The Appeals and Grievances Manager is responsible for overseeing these activities. Appeals and Grievances will be responsible for sending notices to members, responding to all appeals and grievances, reporting and maintaining logs and files.
2. Elderplan will designate one or more qualified personnel who were not involved in any previous level of review or decision-making to serve on the Appeals Committee and review the appeal. If the appeal pertains to clinical matters, the personnel must include licensed, certified or registered health care professionals
3. The Appeals and Grievances Committee, made up of administrative and clinical peer reviewers, may render adverse determinations in the appeal process. Only clinical peer reviewers other than the clinician who rendered the original determination will review appeals. The Committee will meet as quickly as needed to decide outstanding appeals on a timely basis and will meet on an ad hoc basis for expedited appeals.
4. The individuals who make decisions on grievances and appeals are individuals who:
   - Were not involved in any previous level of review or decision- making, and;
   - If deciding any of the following, are health care professionals who have appropriate clinical expertise in treating the member's condition or disease:
     - An appeal of a denial that is based on lack of medical necessity.
     - A grievance regarding denial of expedited resolution of an appeal
     - A grievance or appeal that involves clinical issues.

Appeals for Medicaid and Medicare Services

1. If the service is covered by both Medicaid and Medicare, the member has the right to choose if he or she wants to follow the Medicaid appeals process or the Medicare appeals process.
   - If the member chooses the Medicare appeals process, the Medicaid process can not

be followed and a Fair Hearing can not be requested.

- If the member chooses the Medicaid appeals process, he or she can decide to also pursue the Medicare appeals process within 60 days of receipt of the notice of action (see attachment "R1b – Notice of Action Request for Services Medicare and Medicaid) regardless of the status of the Medicaid Advantage Plus appeal.

2. If the member files an appeal but does not indicate which process he or she wishes to follow, the Medicaid appeals process will be assigned.

IV. RIGHT TO FAIR HEARING AND EXTERNAL APPEAL

1. If a member receives an adverse determination concerning his or her appeal or if the member receives a notice of termination, reduction, or suspension of services as a result of his or her appeal, he or she will also receive notice of both the right to a Fair Hearing and the right to External Appeal along with a cover letter (see attachment "D4 – Appeal Rights Denial Cover") explaining the forms and giving the dates of the appeal and the date of the denial decision. If both are filed, the State Fair Hearing decision is the one that counts.
2. Rights to a Fair Hearing will be explained using the "Medicaid Advantage Plus Plan Action Taken – Denial of Benefits" (see attachment) form. The form must be used any time the Plan makes an adverse determination. The "Medicaid Advantage Plus Plan Action Taken – Termination, Reduction or Suspension of Benefits" form (see attachment) must be used if the member receives a notice of termination, reduction, or suspension of services as a result of an appeal. These forms explain the member's rights to a Fair Hearing, who to contact, representation and timeframes. If the member needs assistance filling out these forms, the Elderplan Appeals and Grievances Department will assist.

Requests for Fair Hearings must be made within sixty (60) days of the member's receipt of the notice of the appeal decision from the Plan. If a member is appealing a reduction, suspension or termination of services that are currently authorized, the member may request to continue to receive these services while the Plan is deciding the appeal. Elderplan must continue the service if the member makes the request no later than 10 days from the postmark of the notice of the Plan's intent to reduce, suspend or terminate the member's services, or by the intended effective date of the action, and the original period covered by the service authorization has not expired. The services will continue until the member withdraws the appeal, the original authorization period for the services has been met or until 10 days after Elderplan mails the notice of the appeal decision, if the decision is not

in the member's favor, unless the member has requested a New York State Medicaid Fair Hearing with continuation of services.

V. REQUIRED PLAN DOCUMENTATION FOR APPEALS

1. Letter indicating the plan will not make a determination on the appeal because the appeal request was not submitted by the member within 45 days of the notice of action. (see attachment "A3 – Appeal Denial Greater Than 45 Day Letter")

2. Written acknowledgement (see attachment "A0 – Appeal Acknowledgement Letter")
   - Name, address and telephone number of the individual or department designated by the plan to respond to the appeal.
   - If a member has requested an expedited appeal and the plan has decided not to expedite the appeal, the acknowledgement (see attachment "D0 – Expedited Denial Letter") must indicate that the appeal will be handled on a standard basis, and inform the member of his/her right to file a grievance and how to do so.
   - The acknowledgement must identify any additional information required by the plan from any source to make the appeal decision. (see attachment "A1 – Appeal Ack Need Info Letter")

3. Notice of plan-initiated extension (see attachment "A1 – Appeal Ack Need Info Letter"), if applicable (may be combined with acknowledgement)
   - Reason for extension
   - How the delay is in the best interest of the member
   - Any additional information that the plan requires from any source to make its determination

4. Plan Decision of overturn resolutions (see attachment "A2 – Appeal Overturn Resolution Letter")
   - Date and summary of appeal
   - Date appeal process completed by plan
   - Reason for determination, and in cases where the determination has a clinical basis, the clinical rationale for the determination
   - Resolution response, including authorization of requested service, start date of service and conditions of future review.

5. Plan Decision of denial (see attachment "D4 – Appeal Rights Denial Cover")
   - Date and summary of appeal.

- Date appeal process completed by plan.
- If decision not in favor of member, State Fair Hearing notice (see attachment "D1 – 438 FH Notice NYC Denial Letter") and description of process for filing Fair Hearing request (and process and timeframes for requesting aid continuing if member is entitled to make such a request as a result of termination, reduction or suspension of services), and how member may obtain assistance from the plan with filing of Fair Hearing request. The "Medicaid Advantage Plus Plan Action Taken – Termination, Reduction or Suspension of Benefits" form (see attachment) must be used if the member receives a notice of termination, reduction, or suspension of services as a result of an appeal.
- If denial of appeal was due to issues of medical necessity or because the service was experimental or investigational, must include a clear statement that the notice constitutes the final adverse determination and procedures for filing an External Appeal (see attachment "D3 – External Appeal Form") and how member may obtain assistance from plan in filing External Appeal.

Elderplan will notify members of the availability of assistance (for language, hearing, speech issues) if a member wants to file Fair Hearing request and/or an External Appeal and how to access that assistance.

The plan must maintain a file on each action and associated appeal (both expedited and standard), if any, that includes (at a minimum):

- a copy of the notice of action;
- the date the appeal was filed;
- a copy of the appeal;
- member/provider requests for expedited appeals and the plan's decision;
- the date of receipt of and a copy of the enrollee's acknowledgment letter of the appeal (if any;
- necessary documentation to support any extensions, and
- the determination made by the plan, including the date of the determination, the titles and, in the case of clinical determinations, the credentials, of the plan's personnel who reviewed the appeal.

Elderplan Letters for Appeals

1. A0 – Appeal Acknowledgement Letter
2. A1 – Appeal Ack Need Info Letter

3. A2 – Appeal Overturn Resolution Letter
4. A3 – Appeal Denial Greater Than 45 Day Letter
5. D0 – Expedited Denial Letter
6. D1 – 438 FH Notice NYC Denial Letter
7. D2 – 438 FH Notice NYC TRS Letter
8. D3 – External Appeal Form
9. D4 – Appeal Rights Denial Cover