

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Kansas has contracted with an ADRC to conduct level of care determinations. Decisions made by the ADRC are subject to state fair hearing review, and notice of that right and related process will be provided by the ADRC with their decision on the LOC determination/redetermination.

In addition, Kansas has contracted with three KanCare managed care organizations (MCOs) who are required to have grievance and appeal processes that meet all relevant federal and state standards, including state fair hearings and expedited appeals. Each MCO has established operational processes regarding these issues, about which they must inform every member, and which are described as follows:

For Amerigroup:

Member Grievance Process

1. Members, or authorized representatives with written consent, may file a grievance with Amerigroup. A grievance is defined as any expression of dissatisfaction with Amerigroup, its services, or the providers within our network.
2. Grievances will be accepted either verbally or in writing.
3. All grievances are recorded in Amerigroup's Grievance System, including information such as the receipt date, the substance and nature of the grievance, member and provider information, the summary of the grievance, etc.
4. Amerigroup mails a written acknowledgement letter within 5 days of receipt of the grievance, letting the member know when they can expect to hear from us with the resolution.
5. Members and authorized representatives are offered the ability to present documentation, information, etc. in person or in writing should they choose to do so.
6. When practitioner review is necessary, the grievance is reviewed by someone not involved in any previous levels of review, and is not a subordinate of anyone involved in any previous levels of review.
7. Amerigroup resolves grievances and provides written notification within 30 days from the date the grievance is received. In cases where it is in the best interest of the member that the resolution timeframe be extended, the grievance will be resolved within 60 days.
8. Written notification will include the disposition of the grievance, as well as instructions on how the member may file a grievance with the State, should they not be satisfied with Amerigroup's resolution.

Member Appeal Process

1. Members, or authorized representatives with written consent, have the right to appeal any medical necessity or benefit adverse decision made by Amerigroup, including those related to coverage, rescission of coverage or to the provision of care or services.
2. Appeals will be accepted verbally or in writing, within 30 days of receipt of the Notice of Action.
3. All appeals are recorded in Amerigroup's Appeal System, including information such as the receipt date, the nature of the appeal, member and provider information, the summary of the appeal, etc.
4. Amerigroup mails a written acknowledgement letter within 5 days of the request, letting the member know we've received the appeal and when they can expect to hear from us with the resolution.
5. Benefits are continued, when all applicable requirements and criteria are met and the member requests that we do so.
6. Members and authorized representatives are offered the ability to present documentation, information, etc. in person or in writing should they choose to do so.
7. The appeal is reviewed by someone not involved in the initial determination or in any previous levels of review, and is not a subordinate of anyone involved in the initial determination or in any previous levels of review.
8. For appeals where medical necessity is in question, Amerigroup appoints at least one person who is a practitioner in the same or a similar specialty that typically treats the medical condition, performs the procedure or provides the treatment, to review the appeal.
9. Amerigroup resolves appeals and provides written notification within the following timeframes:
 - a. Standard Appeals: Within 14 calendar days, except in the case that it is in the best interest of the member to extend the

decision timeframe, in which case Amerigroup will resolve and notify within 30 calendar days.

b. Expedited Appeals: Within 3 calendar days, except when an appeal is related to an ongoing emergency or denial of a continued hospitalization, in which case Amerigroup will resolve no more than one business day after receiving the request. 10. Written notification will include the decision, the reason for the decision and criteria upon which the decision was made. For those not resolved wholly in the member's favor, the notification will also include timeframes and instructions on how to file a State Fair Hearing.

For United Healthcare:

Grievance Process

KanCare members have the right to file a grievance. A grievance is any expression of dissatisfaction about any matter other than an Action. (An "Action" is the denial or limited authorization of a requested service.) Members can file a grievance if they are not happy with the way they were treated, the quality of care or services they received, if they have problems getting culturally competent care, or any provider billing issues. If members need help filing a grievance, UnitedHealthcare Community Plan (UHC) has designated Member advocates to assist members in understanding and using our grievance system. UHC's Member Advocates can assist members with writing or filing a grievance and assist them through the grievance process until the issue is resolved. UnitedHealthcare Community Plan will acknowledge member grievances within ten (10) working days, and will attempt to resolve the grievance right away. UHC will resolve the grievance within 30 business days and respond to the member in writing.

Appeal Process

KanCare members have the right the appeal any denial or limited authorization of service (a service that was denied, reduced or ended early). Members must file their appeal within 30 days of receipt of the Notice of Action letter. UHC will acknowledge the request for appeal within five (5) business days and will send our decision within 14 calendar days. This timeframe may be extended by plan, with State approval, or by the member, if requested. UnitedHealthcare Community plan can help the member file an appeal verbally. Within five (5) business days of the verbal request, UHC will let the member know in writing that we received their appeal. The member may choose someone, including an attorney or provider, to represent them and act on their behalf. They must do this in writing or, if they are not able, can request assistance from UHC for authorizing a representative.

Expedited (faster) Decisions

If the member or their doctor wants a fast decision because they believe the member's health is at risk, they can request an expedited review of an Action. UnitedHealthcare Community Plan will contact the member and provider with our decision within 3 working days of receiving the request for an expedited review. This timeframe may be extended up to 14 days if the member requests an extension or UHC obtains the State's approval that there is need for additional information and the delay is in the member's best interest. We will communicate that decision to the member.

For Centene/Sunflower:

Grievance Process

Sunflower State Health Plan (Sunflower) recognizes the importance of KanCare member's right to have their grievances heard and addressed as soon as possible free from the threat of discrimination or retaliation. Members may file a grievance for a variety of reasons including; they are dissatisfied with the way they were treated by a provider, they received poor quality of care or services, they have problems getting culturally competent care. Sunflower will record the reason or cause of all grievances that are received so they can be analyzed for trends that need to be addressed.

Members receive education about how to file a grievance with Sunflower and about the grievance process in a variety of ways; in the Member Handbook, on the Sunflower website, through the Member Portal, and at least annually in our Member Newsletters. In addition, Member Service Representatives (MSRs) and Care Management (CM) staff are often the Member's first point of contact when filing a grievance or appeal. All MSR and CM staff is trained to assist the member in understanding the grievance process and document and resolve the Member's concern during this first contact whenever possible. If more time is needed, SSHP's Grievance and Appeals Coordinators will investigate and work to resolve the grievance issue and assist the member through the grievance process until the issue is resolved.

A member, or member's authorized representative, may contact SSHP at any time to file a grievance. Members may file a grievance orally, in person, through the Sunflower Member Portal, or in writing by mail, facsimile, electronic mail.

A member must file a grievance within 180 days of occurrence of the issue giving rise to the grievance. Sunflower State Health Plan will acknowledge a member grievance in writing within ten (10) business days of receipt and will attempt to resolve the grievance right away. SSHP will resolve the grievance within 30 business days and send the member written notification of the resolution or decision that was reached.

Appeal Process

KanCare members have the right to appeal any service denial or limited authorization of service (a service that was denied, reduced or ended early). Members must file an appeal within 30 days of receipt of Sunflower's Notice of Action letter that informs them of the service denial or limit.

Sunflower's Member Service Representatives, Care Managers or Grievance and Appeals Coordinator will help a member file an appeal verbally or in writing and assist them in the appeals process. If a member files a verbal appeal, it must be followed up in writing.

If the member chooses to have someone file an appeal on their behalf and represent them, such as a family member or provider, they must do this in writing. Sunflower will assist the member in authorizing someone to represent them.

SSHP will notify members in writing that we received their appeal within (5) business days of receipt. The acknowledgement letter will include all of the members' rights in the appeal process. Sunflower will then send the member our appeal decision within 14 calendar days. This timeframe may be extended an additional 14 calendar days, with State or member approval, if more information is needed to make a decision.

Expedited Appeals

If the member, or their authorized representative, believes the member's health is at risk, they can request an expedited review of a service denial or limitation. This means that Sunflower must reach a decision on the appeal request within 3 working days of receiving the request. Sunflower will notify the member or representative in writing of the expedited appeal decision.

This timeframe may be extended up to 14 calendar days if the member requests an extension or if Sunflower obtains the State's approval that there is need for additional information and the delay is in the member's best interest. Sunflower will notify the member or representative when an extension is needed.

In addition, all three MCOs will advise members of their right to a State Fair Hearing:

Members also have the right to appeal service denials or limitations directly to the Kansas Office of Administrative Hearings (OAH). They can request a hearing from OAH:

- At the same time they appeal to the MCO;
- After they have exhausted their appeal rights with the MCO;
- Or, instead of appealing to the MCO.

If a member's request was for an expedited appeal, they cannot file a State Fair hearing until they have received an appeal decision from the MCO. Members must file for a State Fair Hearing within 30 days from the date they receive a Notice of Action letter from the MCO.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*
- No. This Appendix does not apply
 - Yes. The State operates an additional dispute resolution process
- b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

- a. **Operation of Grievance/Complaint System.** *Select one:*

No. This Appendix does not apply

- Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

- b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

Under the KanCare program, nearly all Medicaid services - including nearly all HCBS waiver services - will be provided through one of the three contracting managed care organizations. However, for those situations in which the participant is not a KanCare member, this grievance/complaint system applies. The Single State Medicaid Agency, Kansas Department of Health and Environment (KDHE), employs the fiscal agent to operate the consumer complaint and grievance system.

- c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Medical Assistance Customer Service Center (MACSC) at the fiscal agent is open to any complaint, concern, or grievance a consumer has against a Medicaid provider. The Consumer Assistance Unit staff logs and tracks all complaints, concerns, or grievances. If a provider has three complaints lodged against them, an investigation is initiated. SRS has access to this information at any time.

The MACSC transfers grievances to the Quality Assurance Team (QAT) on the date received. QAT has three (3) days to contact the grievant to acknowledge the grievance and thirty (30) days to complete the research and resolution. If more time is needed, QAT must request additional time from the state Program Manager.

QAT trends grievances on a monthly basis. Criterion for further research is based on number of grievances per provider in a specific time frame.

Consumers who are not part of the KanCare program are educated that lodging a complaint and/or grievance is not a pre-requisite or substitute for a Fair Hearing and is a separate activity from a Fair Hearing. This information may also be provided by the PD Waiver Program Manager.