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**LCI Service Provider Contract**

**Attachment 2**

**Appeals and Grievance Policy**

**DEFINITIONS:**

**Adverse Benefit Determination:** Includes any of the following:

1. The denial of functional eligibility under Wis. Stat. § 46.286(1)(a) as a result of the MCO’s administration of the Long-Term Care Functional Screen (LTCFS), including a change from nursing home level of care to non-nursing home level of care.
2. The denial or limited authorization of a requested service that falls within the benefit package specified in Addendum VI, including the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit.
3. The reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount of time or duration and that amount or duration has expired.
4. The denial, in whole or in part, of payment for a service that falls within the benefit package specified in Addendum VI. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a “clean claim” under 42 CFR § 447.45(b) is not an adverse benefit determination.
5. The denial of a member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.
6. The denial of a member’s request to obtain services outside the MCO’s network when the member is a resident of a rural area with only one managed care entity.
7. The failure to provide services and support items included in the member’s MCP in a timely manner, as defined by the Department.
8. The development of a member-centered plan that is unacceptable to the member because any of the following apply.
   1. The plan is contrary to a member’s wishes insofar as it requires the member to live in a place that is unacceptable to the member.
   2. The plan does not provide sufficient care, treatment, or support to meet the member’s needs and support the member’s identified outcomes.
   3. The plan requires the member to accept care, treatment, or support items that are unnecessarily restrictive or unwanted by the member.
9. The involuntary disenrollment of the member from the MCO at the MCO’s request.
10. The failure of the MCO to act within the timeframes of this article for resolution of grievances or appeals. (XI.B.1.)

An “adverse benefit determination” is not:

1. A change in non-residential provider;
2. A change in the rate the MCO pays a provider;
3. A termination of a service that was authorized for a limited number of units of service or duration of a service as defined in Article V.K.e. a. and b.; or;
4. An adverse benefit determination that is the result of a change in state or federal law; however, a member does have the right to a State Fair Hearing in regard to whether he/she is a member of the group impacted by the change.
5. The denial of authorization or payment for a service or item that is not inside the benefit package.
6. A denial, in whole or part, of a payment for a service solely because the claim does not meet the definition of a “clean claim” under 42 CFR § 447.45(b).
7. The denial of authorization for remote delivery of a waiver service or a state plan service delivered via interactive telehealth.
8. The denial of a member’s request to self-direct a service or the limitation of a member’s existing level of self-direction. (XI.B.1.)

**Appeal**: A request for LCI review of an “adverse benefit determination.” If a member is dissatisfied with LCI’s appeal decision, he or she can request a State Fair Hearing.

**Appeal and Grievance System:** The term “Appeal and Grievance System” refers to the overall system LCI implements to handle appeals of adverse benefit determinations and grievances, as well as the processes to collect and track information about them.

**Grievance:** An expression of a member’s dissatisfaction about any matter other than an “adverse benefit determination.” When a member expresses dissatisfaction about any matter other than an adverse benefit determination, the member is expressing a grievance.

**State Fair Hearing:** Means a de novo review under Ch. HA 3, Wis. Admin. Code, before an impartial administrative law judge of an action by the Department, a county agency, a resource center, or an MCO.

**POLICY:**

*General Requirements*

1. LCI’s Board of Directors has delegated the responsibility to review and resolve appeals and grievances to LCI’s Appeal and Grievance Committee.
2. The member will be oriented to the appeal and grievance process within 60 days of enrollment. This orientation will be provided in a manner that is understandable to the member or the member’s representative. The orientation will include review of the section on appeals and grievances in the member handbook. IDT staff will review the appeal and grievance procedures with members and/or the member’s representative at least annually during formal Member-Centered Plan (MCP) reviews.
3. All newly hired and existing LCI staff will receive training on the appeal and grievance systems and their role in the system. Training on this policy and procedure is included in the new employee orientation.
4. Members have the right to file an appeal regarding the adverse benefit determinations defined above and have the right to grieve an action or inaction of LCI that the member perceives as negatively impacting them.
5. Authority to File:
   1. A member or a member’s legal decision maker or anyone acting on the member’s behalf with the member’s written permission may file an appeal with LCI regarding any LCI adverse benefit determination.
   2. A member or a member’s legal decision maker or anyone acting on the  
      member’s behalf with the member’s written permission may file a  
      grievance with LCI.
6. LCI must allow members to involve anyone the member chooses to assist in any part of the grievance and appeal process, including informal negotiations.
7. Members are encouraged to attempt to informally resolve their issues before filing a grievance or appeal. The IDT staff are the first level of support when a member is dissatisfied. The member’s IDT staff is usually in the best position to deal with issues directly and expeditiously. Unless contrary to the expressed desire of the member, the IDT will attempt to resolve the issue through internal review, negotiation, or mediation if possible.
8. LCI has designated a Member Rights Specialist (MRS). If the IDT cannot resolve the issue, it will refer the member to the MRS or offer assistance to the member or legal decision maker who wishes to file a grievance or appeal.
9. When a concern cannot be resolved through internal review, negotiation, or mediation:
   1. LCI’s Appeal and Grievance Procedure is the next step for resolving differences.
   2. Department Review is the final process in resolving member grievances.
   3. The State Fair Hearing process is the final administrative review process for resolving members’ appeals of adverse benefit determinations.
   4. Other remedies may be available to members, depending on the circumstances and/or issues.
10. The MRS will offer assistance to members in submitting appeals and grievances. The MRS assigned to assist a member in a specific circumstance may be responsible for scheduling and facilitating meetings but may not be a member of the LCI Appeal and Grievance Committee that considers the specific circumstance. The MRS may not represent LCI at any hearing level. The MRS responsibilities include:
    1. Assist members and legal decision makers to understand the appeal or grievance options;
    2. Help the member and legal decision maker to complete any required paperwork to file the appeal or grievance; and
    3. Attempt to resolve issues through internal review, negotiation, or mediation, unless contrary to the expressed desire of the member.
    4. Assisting the member with gaining access to their record, including medical records and any other documents as records considered during the appeal process.
    5. Maintaining an adequate pool of trained Committee members including members or individuals eligible to receive Family Care benefits in any of the target populations served by LCI and community members who have an interest in the long-term care system.
    6. Facililtate LCI appeal and grievance hearings.
    7. Maintaining timely documentation and updates to the LCI Appeal Log throughout an appeal or grievance.
    8. Ensure LCI is utilizing the most current Department standardized templates to support the Appeal and Grievance system.
11. LCI upholds a member’s right to have access to a fair, equitable, and confidential appeal and grievance system throughout their enrollment with LCI. LCI will not retaliate against members, providers, or other advocates acting on the member’s behalf as a result of filing an appeal or grievance.
12. LCI will provide reasonable assistance to members with all aspects of completing and filing necessary forms and taking other procedural steps, such as: assistance with committing an oral grievance or appeal to writing and providing auxiliary aids and services upon request (such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability). LCI is responsible for the cost of interpreters when a member is utilizing the Appeal and Grievance system.
13. The member and the member’s representative or the legal representative of a deceased member’s estate, the Department, and LCI will be considered parties to the appeal.
14. *One Level of Appeal:* LCI will only have one level of appeal and a member must exhaust this level of appeal before he or she can request a State Fair Hearing.
15. *Opportunity to Present Evidence:* A member shall have a reasonable opportunity, in person and in writing, to present evidence, testimony and legal and factual arguments, in an LCI grievance, LCI appeal, or State Fair Hearing. In an expedited review, LCI will inform the member sufficiently in advance of the expedited appeal resolution timeframe and limited time available to present evidence and testimony and make legal and factual arguments.
16. *Provision of Case File:* LCI will ensure that the member is aware the member has the right to access their case file, free of charge, and to be provided with a free copy of the case file. The Case File must be provided to the member sufficiently in advance of the appeal resolution timeframes.
    1. Case file in this context means all documents, records, and other information relevant to the LCI’s adverse benefit determination and the member’s appeal of that adverse benefit determination. This includes, but is not limited to, medical necessity criteria, third party records LCI relied upon to make a service authorization decision, LTCFS results, any processes, strategies, or evidentiary standards used by LCI in setting coverage limits and any new or additional evidence considered, relied upon, or generated by LCI (or at the direction of the LCI) in connection with the appeal of the adverse benefit determination.
17. *Cooperation with Advocates:* LCI will make reasonable efforts to cooperate with all advocates a member has chosen to assist the member in an appeal or grievance.
    1. Advocate (as used here) means an individual whom or organization that a member has chosen to assist in articulating the member’s preferences, needs, and decisions.
    2. Cooperate means to provide any information related to the member’s eligibility, entitlement, cost sharing, care planning, care management,  
       services, or service providers to the extent that the information is  
       pertinent to matters in which the member has requested the advocate’s assistance. To assure that a member who requests assistance from an advocate is not subject to any form of retribution for doing so.
    3. Unauthorized release of member information is not allowed.
18. *Reversed Appeal Decisions:* If the LCI appeal process or State Fair Hearing process reverses a decision to deny, limit, or delay services that were not furnished during the appeal, LCI must authorize or provide the disputed services promptly and as expeditiously as the member’s health condition requires but no later than 72 hours from the date it receives notice reversing the decision. If the LCI appeal process or State Fair Hearing process reverses a decision to deny authorization of services, and the member received the disputed services during the appeal, LCI must pay for those services.
19. *Continuation of Benefits While an MCO Appeal or State Fair Hearing are  
    Pending:* 
    1. Services shall be continued by LCI throughout the local LCI appeal process and State Fair Hearing process in relation to the initial adverse benefit determination if all of the following criteria are met:
       1. The member files the request for an appeal timely;
       2. The appeal involves the termination, suspension, or reduction of previously authorized services;
       3. The period covered by the original authorization has not expired;
       4. The member makes a timely request (submitted on or before the effective date in the Notice of Adverse Benefit Determination (NOA) or LCI appeal decision) for continuation of benefit. If the request is timely, LCI must continue the benefits even if a previously authorized time period or service limit is reached during the course of the appeal process.
    2. If, at the member’s request, LCI continues or reinstates the member’s services while the appeal or State Fair Hearing is pending, the services must be continued until one of the following occurs:
       1. The member elects to withdraw the appeal or request for State Fair Hearing;
       2. The member fails to request a State Fair Hearing and continuation of benefits within ten (10) calendar days after LCI sends the notice of adverse resolution (decision) to the member’s appeal. In this context, sends, means putting a hard copy notice in the mail or transmitting the notice to the member electronically. If sending electronically, reference LCI Electronic Communication of Protected Health Information and Member Materials Policy and Procedure.
       3. A State Fair Hearing decision is issued upholding LCI’s reduction, suspension, or termination of services.
    3. A member does not have a right to continuation of benefits:
       1. When grieving a change in provider that is the result of a change in LCI’s provider network due to contracting changes; however, in such a situation the member does have a right to appeal based on dissatisfaction with their MCP.
       2. When grieving adverse benefit determinations that are the result of a change in state or federal law; however, in such a situation a member does have the right to appeal whether they are a member of the group impacted by the change.
    4. If the final resolution of the appeal or State Fair Hearing, excluding eligibility appeals, is adverse to the member (i.e., upholds LCI’s adverse benefit determination), LCI will not recover the cost of services that have been continued.
20. *Information to Providers:* LCI’s Service Provider Contract outlines LCI’s policy and procedure related to appeals and grievances. All contracted LCI service providers:
    1. Shall agree to forward records to LCI related to member appeals and grievances within 15 business days of the request, or immediately if the appeal or grievance is expedited.
    2. Must recognize that members have the right to file appeals and grievances and will assure that such adverse benefit determinations will not adversely impact the way care is delivered.
    3. Will cooperate and not interfere with a member’s appeals or grievances.
       1. LCI will not take punitive action against a provider who requests or supports a member’s request for an appeal or grievance.

**Notification of Appeal Rights in Other Situations**

1. Requirement to Provide Notification of Appeal Rights: LCI must provide members with a notice of adverse benefit determination in the following circumstances.
   1. Change in Level of Care from Nursing Home to Non-Nursing Home: LCI will mail, or hand deliver the Department issued Notice of Change in Level of Care form which clearly explains the following:
      1. Notification of appeal rights with LCI when LCI administers a LTCFS that results in a reduction of the member’s LOC from NH to NNH.
      2. Notification that clearly explains the potential impact of the change.
      3. A member’s right to request a functional eligibility re-screening
         1. A functional rescreen shall be completed by a different screener within ten (10) calendar days of a request by a member or member’s legal decision maker.
         2. A notice must be mailed or hand-delivered to the member on the date the screen is calculated and an effective date of not less than fifteen (15) calendar days from the date the screen is calculated.
      4. Member’s right to request a State Fair Hearing following LCI appeal decision or failure to issue a decision within the appropriate timeframes.
      5. LCI does not provide notification to the member of a change in level of care when the member is found to no longer meet any level of care because the ForwardHealth interChange system will automatically issue a Notice of Loss of Functional Eligibility to the member which includes an explanation of the member’s appeal rights. LCI will continue to provide services until the date of disenrollment.
      6. If the member remains enrolled at the non-nursing home level of care a reduction or termination of any service as a result of the change in level of care, LCI must provide an additional notice of adverse benefit determination.
   2. Adverse LCI Grievance or Appeal Decision
      1. When LCI makes a decision in response to a member’s appeal or grievance that is entirely or partially adverse to the member it must on the date of the decision mail or hand deliver a written notification to the member of the reason for the decision and any further appeal or grievance rights.
         1. For appeal decisions, LCI will use the Department mandated templates for when an LCI decision is being upheld, LCI decision is reversed and LCI notification of extension for decision.
      2. Involuntary Disenrollment of the Member from LCI at the LCI’s Request
         1. All requested disenrollments must be approved by the Department and when the Department approves the request, the ForwardHealth interChange system will automatically issue a Notice of Disenrollment to the member which includes an explanation of the member’s appeal rights.
      3. Other Adverse Benefit Determinations
2. A member has the right to appeal other adverse benefit determinations defined in this policy. On the date LCI becomes aware of any such adverse benefit determination, the LCI will mail, or hand deliver the written notification of the right to appeal these adverse benefit determinations with LCI and the right to request a State Fair Hearing following LCI’s appeal decision or LCI’s failure to issue a decision within the appropriate timeframes.
3. Timing of Notification of Appeal Rights
   1. Loss or Change of Functional Eligibility: When administration of the LTCFS results in a loss or change in functional eligibility under Wis. Stat. § 46.286(1)(a), the screener shall verify the results and then immediately transfer the screen results to CARES. The screen results will also be automatically updated in ForwardHealth interChange.
      1. If the LTCFS results in a complete loss of functional eligibility for the program, the member will be automatically disenrolled in ForwardHealth interChange and the interChange system will automatically issue a Notice of Loss of Functional Eligibility to the member. LCI will continue to provide services until the date of disenrollment.
      2. If the LTCFS results in a change in level of care from the nursing home level of care to the non-nursing home level of care, LCI will verify the result and mail or hand deliver a notice of change in level of care on the date the screen was calculated, with an effective date not less than fifteen (15) calendar days from the date the screen is calculated. The notice will include notification of appeal rights informing the member of the change in level of care. If the member remains enrolled at the non-nursing home level of care and LCI reduces or terminates any service as a result of the change in level of care, LCI provide an additional notice of adverse benefit determination in accordance with Article XI.D.5.b.
   2. Adverse MCO Grievance or Appeal Decision
      1. Appeals: LCI must mail or hand-deliver a written decision regarding an appeal to the member and the member’s legal decision maker, if applicable, within the timeframes specified in Article XI. F.5.e. and f. When LCI’s decision is entirely or partially adverse to the member, the decision must include notice of the member’s right to request a State Fair Hearing. The notification shall establish the effective date of the implementation of the decision not less than fifteen (15) calendar days from the date of the notification.
      2. Grievances: LCI must mail or hand-deliver a written decision regarding a grievance to the member and the member’s legal decision maker, if applicable, within the timeframes specified in Article XI.F.4.e.
         1. When LCI’s decision is entirely or partially adverse to the member, the decision must include the reason for the decision and the member’s right to request DHS Review of LCI’s grievance decision.