

MEMBER APPEALS AND GRIEVANCES

Copies of AlohaCare's member grievance and appeal policies and procedures are available upon request. AlohaCare provides assistance to members in filing appeals or grievances, including interpreter services and access for TTY/TTD users.

Authority to File

A member or his/her personal representative (for example, a parent or legal guardian of a child) may file an appeal or grievance orally or in writing. A provider or other individual calling to file an oral appeal or grievance on behalf of the member must provide written or verbal authorization from the member. The member's written authorization should be faxed or mailed to the Grievance Coordinator. The member may also call AlohaCare to request to file a verbal authorization and the AlohaCare staff will complete an Authorization to Disclose Protected Health Information form.

Member Appeals

Members may file an appeal within thirty (30) calendar days of the notice of an adverse action made by AlohaCare. An adverse action is defined as any of the following:

- 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
- The denial, in a whole or in part, of payment for a service
- The failure to provide services in a timely manner, according to the appointment and availability standards established by Med-QUEST
- Unreasonable delays in service or appeals not acted upon within prescribed timeframes
- For a rural area recipient, the denial of a recipient's request to obtain services outside the network for certain circumstances, including the following:
 - The denial of member's request to obtain services outside the network if there is no other suitable provider (in terms of training, experience, and specialization) in the network
 - If the provider has been a primary source of service to the recipient and the provider does not choose to join the network or the provider does not meet the qualifications to join the network
 - If the network providers will not perform a covered service due to moral or religious objections
 - If the recipient needs related services unavailable within the network to avoid risk of further harm
 - If the state determines that other circumstances warrant out-of-network treatment

Written Appeals

Written appeals should be sent to:

AlohaCare
Attention: Grievance Coordinator
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814
Fax: (808) 973-2140

A provider or other individual filing a written appeal on behalf of the member must obtain and include a written authorization from the member with the appeal submission. If someone other than the member or personal representative files a written appeal without the member's written authorization, the Grievance Coordinator will contact the person filing the grievance and inform him/her of the need for member authorization.

Oral Appeals

Members, personal representatives, or other authorized representatives may call the Customer Service Department at (808) 973-1650 (Oahu), 1-800-434-1002 (toll free anywhere in the State of Hawaii) or TTY/TTD users can call us at 1-877-447-5990 and AlohaCare staff will assist the member in filing the appeal. The member will be informed that all appeals must be in writing and that we will send the completed form for review and signature. The form is forwarded to the Grievance Coordinator to be sent with the acknowledgment letter. The oral request will establish the receipt date; however, if the completed Member Appeal Form with the member's signature is not received within thirty (30) days of original contact, the appeal will be denied as invalid. A notification will be sent to the member in writing.

Process

All appeals will be thoroughly investigated by gathering all documentation, records, or any other information submitted by all relevant parties, without regard to whether such information was submitted or considered in the initial consideration of the case, and using the applicable statutory, regulatory and contractual provisions, as well as AlohaCare's policies and procedures.

AlohaCare will render a resolution of the appeal as expeditiously as the member's health requires, but no longer than thirty (30) calendar days from the receipt date of the appeal except in the case of expedited appeal. AlohaCare will take into account all documents, records, or other information submitted relating to the case. A letter of resolution will be mailed to the member and copies are sent to all parties whose interest has been affected by the decision. The recipients will include any provider that may be affected by the decision. The effective date of the decision will be the postmarked date of the mailing.

AlohaCare may grant an extension of the resolution deadline of up to fourteen (14) calendar days if the member requests the extension or if additional information is needed. If AlohaCare determines that additional information is needed, a letter will be sent to the member. The content of the notification will include the following details:

- Nature of the appeal
- Reason for the extension of the decision and how the extension is in the member's best interest

If the appeal is not resolved wholly in favor of the member, the member may access the state administrative hearing process by either calling the member's eligibility worker or submitting a letter to the State within thirty (30) calendar days from the receipt of the member's appeal determination. Members must exhaust AlohaCare's internal appeal system prior to requesting an administrative hearing. The member has the right to representation during such hearing.

The address for sending a written request is:

Med-QUEST Division
Health Care Services Branch
P.O. Box 700190
Kapolei, HI 96709-0190

The member can also request a hearing by calling Med-QUEST at (808) 692-8094 and asking for the AlohaCare Plan Liaison.

During the administrative hearing process AlohaCare will continue the member's benefits if:

- The member requests an extension of benefits;
- The request for state administrative hearing is filed in a timely manner, meaning on or before the later of the following:
 - Within ten (10) days of the health plan mailing the notice of adverse action; or
 - The intended effective date of the health plan's proposed adverse action.
- The appeal or request for state administrative hearing involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider; and
- The original period covered by the original authorization has not expired.

If AlohaCare continues or reinstates the member's benefits while the appeal or state administrative hearing is pending, the health plan continues all benefits until one of the following occurs:

- The member withdraws the appeal;
- The member does not request an administrative hearing within ten (10) days from when the health plan mails a notice of adverse action;
- A State administrative hearing decision adverse to the member is made; or
- The authorization expires or authorization service limits are met.

If the Health Plan or the State administrative hearing officer reverses a decision to deny, limit, or delay services:

- AlohaCare will authorize or provide the disputed services that were not furnished while the appeal was pending, promptly, and as expeditiously as the member's health condition requires.
- AlohaCare will pay for the disputed services the member received while the appeal was pending.

The State reaches its decision within ninety (90) days of the date the member filed the request for an administrative hearing with the State.

Expedited Member Appeal

An expedited appeal shall be authorized if the application of the standard review time frame may:

- a. Seriously jeopardize the life or health of the member;
- b. Seriously jeopardize the member's ability to attain, maintain or regain maximum functioning; or
- c. Subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the expedited appeal.

Written Filing

Written expedited member appeals should be mailed or faxed to:

AlohaCare
Attention: Expedited Appeal Request
1357 Kapi'olani Blvd., Suite 1250
Honolulu, HI 96814

Oral Filing

Members, personal representatives or other authorized representatives may call the Customer Service Department at (808) 973-1650 (Oahu) or 1-800-434-1002 (toll free anywhere in the State of Hawaii) or TTY/TDD users can call us at 1-877-447-5990 and AlohaCare staff will assist the member in filing the expedited appeal. The caller should specifically state that he/she is requesting an expedited appeal.

Process

Upon receipt, the request will be forwarded immediately to a Senior Clinical staff member or a Medical Director, as appropriate.

If the request does not meet the criteria for an expedited appeal resolution, AlohaCare will transfer the request to the timeframe for a standard appeal resolution. The member will be notified of the denial of expedited appeal request verbally. AlohaCare will also send out a written notice within two calendar days and in that notice explain how to file a grievance if the member disagrees with the decision to deny the expedited appeal request.

If the request meets the criteria for an expedited appeal resolution, an appropriate review will be completed by the clinical staff as expeditiously as the member's health condition requires within seventy-two (72) hours of receipt. AlohaCare shall make reasonable efforts to provide oral notice to the member with the appeal determination.

If the appeal is not resolved wholly in favor of the member, the member has the right to request an Expedited State Fair Hearing within three (3) days of notification of denial. The member may request an expedited state administrative hearing only when AlohaCare has provided an expedited appeal and the action of the appeal was adverse to the member (action denied). The member must contact a MQD Plan Liaison by calling Med-QUEST at (808) 692-8094 to request an Expedited State Fair Hearing. An expedited state administrative hearing will be heard and determined within three (3) business days with no opportunity for extension on behalf of the state. The member has the right to representation during such hearing.

The member has the right to request that benefits continue while the expedited hearing is in process.

Member Grievance

Members may file a grievance if they express any dissatisfaction with regard to anything other than an adverse action. This could include the following:

- Health Plan's or provider's operations
- Health Plan's or provider's activities
- Health Plan's denial of an expedited appeal request
- Health Plan's or provider's failure to respect the recipient's rights
- Health Plan's or provider's or staff behavior
- Provider quality of care
- Health Plan's privacy practices – copies of these grievances are also forwarded to the AlohaCare Privacy Officer

Written Grievance

Written grievances should be sent to:

AlohaCare
Attention: Grievance Coordinator
1357 Kapi'olani Blvd., Suite 1250
Honolulu, HI 96814

Oral Grievance

Members, personal representatives or other authorized representatives may call the Customer Service Department at (808) 973-1650 (Oahu) or 1-800-434-1002 (toll free anywhere in the State of Hawaii) or TTY/TDD users can call us at 1-877-447-5990 and AlohaCare staff will assist the member in filing the

grievance. A provider or other individual calling to file an oral grievance on behalf of the member must provide written or verbal authorization from the member. Member's written authorization should be faxed or mailed to the Grievance Coordinator.

Process

Each grievance will be thoroughly investigated by gathering all documentation, records, or any other information submitted by all relevant parties and using the applicable statutory, regulatory and contractual provisions, as well as AlohaCare's policies and procedures.

AlohaCare will render a resolution of the grievance as expeditiously as the member's health requires but no longer than thirty (30) calendar days from the receipt date. AlohaCare will take into account all documents, records, or other information submitted by the grievant, provider or facility rendering the service relating to the case. A letter of resolution will be mailed to the grievant and copies are sent to all parties whose interest has been affected by the decision. The date of the letter is considered the decision date.

AlohaCare may grant an extension of the resolution deadline of up to fourteen (14) calendar days if the member requests an extension. A fourteen (14) calendar day extension can also be given if AlohaCare determines that additional information is needed, in which case a letter will be sent to the grievant. The content of the notification will include the following details:

- Nature of the grievance
- Reason for the extension of the decision and how the extension is in the member's interest

If the disposition of the grievance does not meet the satisfaction or expectations of the member, members have a right to request a Grievance Review from the State within 30 calendar days of receipt of the grievance disposition. Members must exhaust AlohaCare's internal grievance system prior to requesting a Grievance Review. For Grievance Review by Med-QUEST, the member may call (808) 692-8094 and ask for the AlohaCare Plan Liaison.), or the member may submit the request in writing to:

Med-QUEST Division
Health Care Services Branch
PO Box 700190
Kapolei, HI 96709-0190

The Med-QUEST Division (MQD) AlohaCare Plan Liaison will review the grievance and contact the member with a determination within 30 calendar days from the day the request for a grievance review is received. The grievance review determination made by the MQD is final.