KanCare | Healthy Blue

Your grievance and appeal rights as a Healthy Blue member

As a Healthy Blue member, you have rights. If you have a concern, we want to help. Asking for help will not affect the care you receive.

If you have questions about your rights or any of the steps below, call us at **833-838-2593 (TTY 711)**, Monday through Friday, 8 a.m. to 5 p.m. Central time.

Grievances and appeals
A **grievance** can be filed for any concern about your care. An **appeal** can be filed if you believe a decision about your care was incorrect. More information about each is below.

Grievances
As defined in 42 CFR §438.400(b), a grievance is an expression of dissatisfaction about any matter other than adverse benefit determination or an action. This may include, but is not limited to:

- The quality of care or services provided and aspects of interpersonal relationships, such as the rudeness of a provider or employee.
- Failure to respect the member's rights regardless of whether remedial action is requested.
- A member's right to dispute an extension of time proposed by the health plan to make an authorization decision.
- If you are not happy with the way you were treated.
- If you are not happy with the quality of care or services you received.
- If you are having problems getting care.
- If you are having billing problems.
- If you are wanting to change health plans.

Filing a grievance
If you are dissatisfied and would like to file a grievance, you or your authorized representative (with your written consent) can file a grievance orally or in writing, at any time.

You can submit your grievance by phone, mail, fax, or through your **Sydney℠ Health** app. You can also download the member grievance form at **https://www.healthybluekansas.com/medicaid/complaints-grievances**. Attach any papers, comments, or information that will help us investigate your issue to the form. A grievance form is not required to submit a grievance.

To submit your grievance by phone, call:	**833-838-2593 (TTY 711)**, Monday through Friday, 8 a.m. to 5 p.m. Central time

healthybluekansas.com/medicaid

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To submit your grievance by fax, send to: **877-881-1305**

To submit your grievance by mail, send to: Grievance Department
Healthy Blue
P.O. Box 62429
Virginia Beach, VA 23466

Please tell us:

- Who is involved in the grievance.
- What happened.
- When it happened.
- Where it happened.
- Why you are not happy with your healthcare services.

If you and/or your representative would like to present evidence in person or by phone, you can request to do so by calling us. We will inform you and/or your representative of the limited time available to present your information.

You can call us at **833-838-2593 (TTY 711)**, Monday through Friday, 8 a.m. to 5 p.m. Central time if you:

- Need help filing your grievance or completing forms.
- Would like to submit your grievance by phone.
- Need to submit your grievance as expedited for urgent medical reasons.

You also have the right to submit a grievance directly with the state, once you have completed our internal grievance process, if you are unable to obtain culturally appropriate care. For more information, please call us at **833-838-2593 (TTY 711)**, Monday through Friday, 8 a.m. to 5 p.m. Central time.

After you file a grievance
Within 10 calendar days from the time we receive your grievance, we will send you a letter confirming it was received. We will research your issue and make a decision as expeditiously as your health condition requires, but no more than 30 calendar days from the date we received your grievance. We will send you a letter with our decision.

Grievance extension
If you need more time to send us information, you can add up to 14 calendar days to the grievance time. The request for additional time to resolve your grievance shall be made two business days in advance of the 30 calendar days allowed to resolve your grievance. We can also add up to 14 calendar days to the grievance time if we need more information to make a decision. We will send you a letter with the reason for the delay within two calendar days and also attempt to contact you by phone. If you disagree with the delay, you have the right to file a grievance.

Appeals
An appeal is a formal request for review of an adverse benefit determination. You or anyone you choose to represent you (with your written consent) during the appeal

process, including an attorney or your doctor, can ask for an appeal if you receive a *Notice of Adverse Benefit Determination* from us telling you a medical service has:

- Been denied or limited.
- Been reduced, suspended, or terminated.
- Not been given in a timely manner.

Filing an appeal
If you are dissatisfied and would like to file an appeal, you or the person you choose to represent you, needs to ask for an appeal within 60 calendar days from the date on the *Notice of Adverse Benefit Determination* letter, plus an additional three calendar days to allow for sending of the notice. You can file your appeal orally or in writing. If you choose someone else to represent you, we will need your written consent. You have the right to give written comments, documents, and other relevant information with your appeal.

You can file an appeal by phone, mail, fax, or through your Sydney Health app.

To submit your appeal by phone:	**833-838-2593 (TTY 711)**, Monday through Friday, 8 a.m. to 5 p.m. Central time
To submit your appeal by fax, send to:	**877-881-1305**
To submit you appeal by mail, send to:	Appeals Department Healthy Blue P.O. Box 62429 Virginia Beach, VA 23466

Expedited appeals
If you think waiting 30 calendar days may harm your health, we may be able to give you an answer within 72 hours. This is called an expedited (faster) appeal. In your request, tell us why you think waiting 30 calendar days would harm your health. You can call us at **833-838-2593 (TTY 711)** or you can also fax your expedited appeal to **877-881-1305**. Please be sure to mark "EXPEDITED" on the request before faxing. We will make a decision and try to call you within 72 hours from the time we receive your appeal. We will also send you a letter with our decision.

If we do not think waiting 30 calendar days will harm your health, we will send you a letter within two calendar days to let you know we will complete your appeal as quickly as we can but within 30 calendar days. We will also try to call to tell you our decision. If you disagree with this decision, you have the right to file a grievance.

After you file an appeal
You can look at your case file. This includes medical records or other papers taken into account during the appeal process. At any time during the appeal process, you can ask us for a copy of all the paperwork at no cost. This includes what we used to make this decision. Within five calendar days from the time we receive your standard appeal, we will send you a letter confirming it was received. We will review your appeal request and make a decision within 30 calendar days from the date we

receive your appeal. Expedited appeals will be resolved within 72 hours of receipt if we agree it is urgent. We will send you a letter with our decision.

Appeal extension
If you need more time to send us information, you can add up to 14 calendar days to the appeal time. The request for additional time to resolve your appeal shall be made two business days in advance of the 30 calendar days allowed to resolve your appeal. We can also add up to 14 calendar days to the appeal time if we need more information to make a decision. We will send you a letter with the reason for the delay within two calendar days and also attempt to contact you by phone. If you disagree with the delay, you have the right to file a grievance.

Continuation of benefits for members receiving non-HCBS Waiver Services and Benefits

You can keep your benefits during the appeal or state fair hearing process if you meet **all** these conditions:

- You asked for your benefits to be continued within 10 calendar days from the mailing date on the *Notice of Adverse Benefit Determination* letter.
- The action has to do with a previously authorized service that has been terminated, reduced, or suspended.
- The services were ordered by an authorized provider.
- The original period of coverage when it was first approved has not ended.
- You asked to extend your benefits timely.

If you want your services continued during an appeal, you have **10 calendar days** from the mailing date on the *Notice of Adverse Benefit Determination* letter to ask us to continue your services during the appeal process. We will issue the Notice of Appeal Resolution within **30 calendar days** after receiving your appeal.

If we do not change our decision, you may ask for a state fair hearing. You must ask for the state fair hearing within **120 calendar days** from the date of the Notice of Appeal Resolution, plus an additional three calendar days to allow for sending of the notice. If you want your services to continue during the state fair hearing process, you must ask for a state fair hearing and continuation of benefits within **10 calendar days** from the mailing date of the Notice of Appeal Resolution.

If the state fair hearing officer changes our decision, and you received the services while the state fair hearing was pending, we will pay for those services.

Please keep in mind that you may have to pay for the continued services if you lose the appeal or state fair hearing.

If we continue your benefits while the appeal or state fair hearing is pending, the benefits will continue until one of the following occurs:

- You withdraw your appeal or state fair hearing request.
- You do not request continuation of benefits within 10 calendar days of us sending a *Notice of Adverse Benefit Determination* letter; or

- A state fair hearing officer upholds our denial.

Continuation of benefits for members receiving HCBS Waiver Services and Benefits

You will keep your benefits during the appeal or state fair hearing process if you meet **all** these conditions:

- You asked for the appeal within 60 calendar days from the date on the *Notice of Adverse Benefit Determination* letter, plus an additional three calendar days to allow for sending of the notice that terminates, suspends, or reduces the previously authorized services and benefits. Or in the case of a state fair hearing, the request for a state fair hearing is filed within 120 calendar days from the date of the Notice of Appeal Resolution, plus an additional three calendar days to allow for sending of the notice.
- The appeal has to do with a previously authorized service that has been terminated, reduced, or suspended.
- The services were ordered by an authorized provider.
- The original period of coverage when it was first approved has not ended.
- If you requested different HCBS waiver services and benefits to replace your previously authorized HCBS waiver services and benefits, and we authorized the new HCBS waiver services and benefits, your previously authorized HCBS waiver services and benefits must be terminated to allow your new HCBS waiver services and benefits to begin. If your new HCBS waiver services and benefits will begin within 63 days of the date of the *Notice of Adverse Benefit Determination* terminating your previously authorized HCBS waiver services and benefits, your previously authorized HCBS waiver services and benefits will be continued only until your new HCBS waiver services and benefits begin.

If you receive a *Notice of Adverse Benefit Determination* letter stating your HCBS services will be changing, we will automatically continue your current HCBS services for **63 calendar days** from the date of the notice to allow you time to ask for an appeal. If you do not ask for an appeal, the current level of HCBS services will change.

If you request an appeal within **60 calendar days** from the date of the notice, plus an additional three calendar days to allow for sending of the notice, we will continue your current level of HCBS services until we issue a Notice of Appeal Resolution. We will issue the Notice of Appeal Resolution within **30 calendar** days after receiving your appeal.

If we do not change our decision, you may ask for a state fair hearing. We will automatically continue your current HCBS services for **123 calendar days** from the date of the Notice of Appeal Resolution to allow you time to ask for a state fair hearing. If you do not ask for a state fair hearing, the current level of HCBS services will change.

If you ask for a state fair hearing within **120 calendar days** from the date of the Notice of Appeal Resolution, plus an additional three calendar days to allow for sending of the notice, we will continue your current level of HCBS services until the hearing decision.

If the state fair hearing officer changes our decision, and you received the HCBS services while the state fair hearing was pending, we will pay for those services. You will not have to pay for the continued services if the appeal decision or state fair hearing decision are not in your favor unless fraud has occurred.

Your benefits will continue during the appeal or state fair hearing process until one of the following occurs:

- You withdraw your appeal or state fair hearing request.
- You do not request an appeal within 60 calendar days of us sending a *Notice of Adverse Benefit Determination* letter, plus an additional three calendar days to allow for sending of the notice, or you do not request a state fair hearing within 120 calendar days from the date of the Notice of Appeal Resolution, plus an additional three calendar days to allow for sending of the notice.
- A state fair hearing officer upholds our denial.
- You request previously authorized HCBS waiver services and benefits to end and be replaced with other HCBS services or that will begin during the sixty-three (63) calendar days from the date of the Notice of Adverse Determination or that will begin during the one hundred twenty-three (123) calendar days from the date of the Notice of Member Appeal Resolution.

State fair hearing
If you are not happy or disagree with our response to your appeal, you or your authorized representative, have the right to ask for a state fair hearing.

Filing a state fair hearing request
To file a state fair hearing, you are required to do both of the following:

- Complete our appeal process.
- Send your request orally or in writing within 120 calendar days from the date you were notified of Healthy Blue's decision to uphold your appeal, plus an additional three calendar days to allow for sending of the notice.

You can file a state fair hearing request by:

- Calling Healthy Blue at **833-838-2593 (TTY 711)**, Monday through Friday, 8 a.m. to 5 p.m. Central time. Or you can mail your request to:
  Healthy Blue

P.O. Box 62429
Virginia Beach, VA 23466

We will forward your request for a state fair hearing to the Office of Administrative Hearings (OAH) within one business day of receiving your request.

- Mailing your request to the Office of Administrative Hearings (OAH) at:
  Office of Administrative Hearings (OAH)
  1020 S. Kansas Ave.
  Topeka, KS 66612

After you file a state fair hearing request
The state OAH is responsible for the state fair hearing and will set up a hearing date when you can present the information you want the state to consider.

If the state fair hearing officer reverses our decision, we will authorize and provide the service as expeditiously as your health condition requires but no later than 72 hours from the date we receive the decision.

If you have questions
You can call us at **833-838-2593 (TTY 711)**, Monday through Friday, 8 a.m. to 5 p.m. Central time.

Healthy Blue is the trade name of Community Care Health Plan of Kansas, Inc. Independent licensee of the Blue Cross and Blue Shield Association.

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan.