Medicare Appeals and

Quality of Care Grievances

Community HealthFirst

April 1, 2014 to March 31, 2015

What kind of information is this?

When you ask for it, the government requires **Community HealthFirst** to provide you with reports that describe **what happened** to formal complaints that **Community HealthFirst** received from their Medicare members. There are two types of formal complaints: **Appeals and Grievances.**

Medicare members have the right to file an appeal or grievance with their Medicare Advantage organization. The next few pages contain information about the appeals and quality of care grievances that **Community HealthFirst** received between April 1, 2014 and March 31, 2015

Each organization will have different numbers of appeals and quality of care grievances, and these numbers can mean different things. For example, and organization might have a small number of appeals and quality of care grievances because the organization talks with members about their concerns and agrees to find solutions. Or an organization might have a small number of appeals and quality of care grievances because its members are not aware of their right to file an appeal or grievance.

How big is **Community HealthFirst**?

Community HealthFirst has about 17,469 Medicare members.

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Information on Medicare Appeals

April 1, 2014 to March 31, 2015

What is an appeal?

An appeal is a formal complaint about **Community HealthFirst's** decision not to pay for, not to provide, or to stop an item or service that a Medicare member believes she/he needs.

If a member cannot get an item or service that the member feels she/he needs, or if the organization has denied payment of a claim for a service the member has already received, the member can appeal. For example, a member might appeal **Community HealthFirst's** decision to stop physical therapy, to deny a visit to a specialist, or to deny payment of a claim.

How many appeals did Community HealthFirst receive?

Community HealthFirst received 188 appeals from its Medicare members. About 11 out of every 1,000 Medicare members appeals **Community HealthFirst's** decision not to pay for or provide, or to stop a service that they believed they needed.

How many appeals did Community HealthFirst review?

Community HealthFirst reviewed 188 appeals during this time period.

What happened?

From the **188** appeals it received from its members:
Community HealthFirst decided to pay for or to provide all services that the member asked for **53%** of the time.

Community HealthFirst decided not to pay for or to provide the services that the member asked for **47%** of the time.

Medicare members withdrew their request before **Community HealthFirst** issued a decision **0%** of the time.

Information on Expedited or "Fast" Appeals

April 1, 2014 to March 31, 2015

What is a "fast" or expedited appeal?	A Medicare member can request that **Community HealthFirst** review the member's appeal quickly if the member believes that his or her health could be seriously harmed by waiting for a decision about a service. This is called a request for an **expedited** or **"fast" appeal.** **Community HealthFirst** looks at leach request and decides whether a "fast" appeal is necessary. By law, **Community HealthFirst** must consider an appeal as quickly as a member's health requires. If **Community HealthFirst** determines that a "fast" appeal is necessary, it must notify the Medicare member as quickly as the member's health requires but no later than 72 hours.
How many "fast" appeals did **Community HealthFirst** receive?	**Community HealthFirst** received **56** requests for "fast" appeals from its Medicare members.
What happened?	When a member requested a "fast" review, **Community HealthFirst** agreed that a "fast" review was needed **96%** of the time. **Community HealthFirst** did not agree to a "fast" review **4%** of the time. This number may include requests by members who the organization many not have believed were in danger or might suffer serious harm.

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Information on Independent Review

April 1, 2013 to March 31, 2014

What is Independent Review of an appeal?

After a member has sent an appeal to **Community HealthFirst,** if the organization continues to decide that it should not pay for or provide all services that the member asked for, **Community HealthFirst** must send all of the information about the appeal to an independent review entity (IRE) that contracts with Medicare, not **Community HealthFirst.**

An independent review provides an opportunity for a new, fresh look at the appeal outside of the organization. CMS' IRE goes over all of the information from **Community HealthFirst** and can consider any new information.

If the IRE does not agree with **Community HealthFirst's** decision, **Community HealthFirst** must provide or pay for the services that the Medicare member requested.

There may be several reasons why the IRE decides to agree with either the Medicare member or **Community HealthFirst.** For example, the IRE may disagree with **Community HealthFirst** because the IRE may have had more information about the appeal.

How many appeals did the IRE consider?

The IRE considered 86 appeals from **Community HealthFirst**.

What happened?

The IRE agreed with the Medicare member's appeal **29%** of the time. This means that in 29**%** of these cases, **Community HealthFirst** ended up paying for or providing all services that these members asked for.

The IRE disagreed with the Medicare member's appeal **70%** of the time. This means that in **70%** of these cases, **Community HealthFirst** ended up **not** paying for or providing all services that these members asked for.

Medicare members withdrew their request for independent review **0%** of the time.

By March 31, 2015 1**%** of appeals were still waiting to be reviewed by the IRE.

NOTE: These percentages may not add to 100% because sometimes the IRE dismisses an appeal.

Information on Quality of Care Grievances

April 1, 2013 to March 31, 2014

What is a quality of care grievance?

A grievance is a complaint that a Medicare member makes about the way **Community HealthFirst** provides care (other than complaints about requests for service or payment). A **grievance** about the **quality of care** is one kind of grievance. For example, a member can file a grievance about the quality of care when the member believes that the service the member received was not timely or correct, when the member had problems getting a service because of long waiting times or long travel distances, or when the wrong kind of doctor or hospital provided the service.

How many quality of care grievances did Community HealthFirst receive?

Community HealthFirst received **59** grievances about the quality of care. About **less than 3.39 out of every 1,000** Medicare members filed a grievance about the quality of care they received from **Community HealthFirst** doctors and hospitals.

Where can I get more information?

If you are a member of **Community HealthFirst**, you have the right to file an appeal or grievance.

You can contact **Community HealthFirst** at 1-800-942-0247 8:00 A.M to 8:00 P.M. seven days a week to resolve a concern you may have tor to get more information on how to file an appeal or grievance. The hearing impaired can Dial 7-1-1 for the TTY line available 8:00 A.M to 8:00 P.M. seven days a week. You may also refer to your Evidence of Coverage for a complete explanation of your rights.

You can also contact a group of independent doctors called a Quality Improvement Organization, at 1-877-588-1123 or 1-855-887-6668 for the TTY line for more information about quality of care grievances or to file a quality of care grievance.