Medicare Appeals and Quality of Care Grievances Independent Health April 1, 2018 – March 31, 2019

What kind of information is this?
When asked, the government requires Independent Health to provide reports that describe what happened to formal complaints that Independent Health 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 Independent Health received between April 1, 2018 and March 31, 2019.

Each organization will have different numbers of appeals and quality of care grievances, and these numbers can mean different things. For example, an 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 solutions. Alternatively, 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 Independent Health?
Independent Health has about 69,092 Medicare members.

INFORMATION ON MEDICARE APPEALS
April 1, 2018 – March 31, 2019

What is an appeal?
An appeal is a formal complaint about Independent Health'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 Independent Health's decision to stop physical therapy, to deny a visit to a specialist, or to deny payment of a claim.

How many appeals did Independent Health receive?
Independent Health received 3,499 appeals from its Medicare members. About 51 out of every 1,000 Medicare members appealed Independent Health's decision not to pay for or provide, or to stop a service that they believed they needed.

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How many appeals did Independent Health review?
Independent Health reviewed 3,212 appeals during this time period.

What happened?
From the 3,499 appeals it received from its members:

- Independent Health decided to pay for or to provide all services that the member asked for 50% of the time.
- Independent Health decided not to pay for or to provide the services that the member asked for 48% of the time.
- Medicare members withdrew their request before Independent Health issued a decision 2% of the time.

INFORMATION ON EXPEDITED OR "FAST" APPEALS
April 1, 2018 – March 31, 2019

What is a "fast" or expedited appeal?
A Medicare member can request that Independent Health 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.

Independent Health looks at each request and decides whether a "fast" appeal is necessary. By law, Independent Health must consider an appeal as quickly as a member's health requires. If Independent Health 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 Independent Health receive?
Independent Health received 302 requests for "fast" appeal from its Medicare members.

What happened?
When a member requested a "fast" review, Independent Health agreed that a "fast" review was needed 95% of the time.

Independent Health did not agree to a "fast" review 5% of the time. This number may include requests by members who the organization may not have believed were in danger or might suffer serious harm.

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INFORMATION ON INDEPENDENT REVIEW
April 1, 2018 – March 31, 2019

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

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 Independent Health and can consider any new information.

If the IRE does not agree with Independent Health's decision, Independent Health 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 Independent Health. For example, the IRE may disagree with Independent Health because the IRE may have had more information about the appeal.

INFORMATION ON INDEPENDENT REVIEW
April 1, 2018 – March 31, 2019

How many appeals did the IRE consider?
The IRE considered 1,535 appeals from Independent Health.

What happened?
The IRE agreed with the Medicare member's appeal 3% of the time. This means that in 3% of these cases, Independent Health ended up paying for or providing all services that these members asked for.

The IRE disagreed with the Medicare member's appeal 96% of the time. This means that in 96% of these cases, Independent Health 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 July 2, 2019, 0% 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.

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INFORMATION ON QUALITY OF CARE GRIEVANCES
April 1, 2018 – March 31, 2019

What is a quality of care grievance?
A grievance is a complaint that a Medicare member makes about the way Independent Health 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 Independent Health receive?
Independent Health received 1,049 grievances about the quality of care. About less than 15 out of every 1,000 Medicare members filed a grievance about the quality of care they received from Independent Health doctors and hospitals.

Where can I get more information?
If you are a member of Independent Health, you have the right to file an appeal or grievance.

You can contact Independent Health at 716-250-4401 or 1-800-665-1502 (TTY: 711) , October 1 – March 31: Monday – Sunday, 8 a.m. – 8 p.m., April 1 – September 30: Monday – Friday, 8 a.m. – 8 p.m., to resolve a concern you may have or to get more information on how to file an appeal or grievance. You may also refer to your Evidence of Coverage for a complete explanation of your rights.

You also can contact a group of independent doctors in New York state, called a Quality Improvement Organization, at 1-866-815-5440 (in New York state only) (TTY: 1-866-868-2289) for more information about quality of care grievances or to file a quality of care grievance.

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