



Enrollee Grievance and Appeal Procedures
HIP VIP Medicare Plans

Grievances

A grievance is any complaint other than one that involves a coverage determination. An enrollee may file a grievance if they have any type of problem with us, or one of our network pharmacies that does not relate to coverage for a prescription drug. For example, an enrollee would file a grievance if they have a problem with things such as waiting times when they fill a prescription, the way a network pharmacist or others behave, being able to reach someone by phone or get the information they need, or the cleanliness or condition of a network pharmacy.

An enrollee or their representative must file a grievance no later than 60 days after the event or incident that precipitated the grievance. Grievances may be filed orally or in writing. All grievances submitted in writing will be responded to in writing. Grievances submitted orally may be responded to either orally or in writing unless the enrollee requests a written response. All grievances related to quality of care, regardless of how the grievance is filed, will be responded to in writing. HIP will notify the enrollee of its decision expeditiously based upon the individual's health status, but no later than 30 days after the date HIP receives the grievance. This time period may be extended by up to 14 days if the enrollee requests such an extension or HIP can justify the need. If HIP extends the timeframe, the enrollee will be immediately notified. Expedited grievances will be responded to within 24 hours. All responses will include a description of how to file a written complaint with IPRO.

Phone Number and Address for Grievances and Appeals:

HIP Health Plan of New York:
Grievance and Appeal Department
P.O. Box 2807
New York, NY 10116-2807
Phone: 1-800-HIP-TALK (1-800-447-8255)
TTY: 1-888-HIP-4TDD (1-888-447-4833)

Coverage Determinations

A coverage determination is a decision:

- not to provide or pay for a Part D drug because the drug is not medically necessary, the drug is obtained from an out-of-network pharmacy, or the drug is not on HIP's formulary;
- about an exceptions request from the tiering structure;
- about an exceptions request for a non-formulary Part D drug;
- about the amount of cost sharing for a drug (excludes Specialty drugs – Tier 4).
- about whether or not an enrollee has satisfied a prior authorization or utilization management requirement.

Failure to make a decision about one of the above in a timely manner when a delay would adversely affect the health of the enrollee is also considered a coverage determination.

Coverage determinations may be requested by a HIP enrollee, a HIP Medicare Prescription Drug Plan member, or their authorized representative. An authorized representative may be a friend, relative or doctor. If an enrollee would like to name an authorized representative, both the enrollee and the authorized representative must sign and date a statement giving the representative permission to act on behalf of the enrollee. Upon request, HIP will provide a form for appointing a representative.

For requests for standard coverage determinations, HIP will notify the enrollee (and prescribing physician as appropriate) of the determination as expeditiously as possible but no later than 72 hours after receipt of the request for the coverage determination, or for an exceptions request, the physician's supporting statement (if one is provided).

For requests for expedited coverage determinations, written notice of the determination will be provided by HIP to the enrollee (and prescribing physician as appropriate) of the determination within 24 hours of the date of the request or receipt of the physician's supporting statement (if one is provided). If the request is granted, HIP will provide notice to the enrollee (and prescribing physician as appropriate) within 24 hours of receiving the request (or for an exceptions request in which a non-formulary drug is requested) or within 24 hours of receiving the physician's supporting statement. If the expedited request is denied, HIP will make the determination within 72 hours of request of physician's statement and give prompt oral notice of the denial of the expedited request which explains (1) HIP's standard process; (2) informs the enrollee of the right to file expedited grievance; (3) informs the enrollee of the right to resubmit the request with a physician's supporting documentation; and (4) provides instructions about HIP's grievance process and its timeframes. We will also send a written notice within 3 calendar days after oral notification of the denial. Note that expedited coverage determinations are not permitted for payment requests.

Phone Number and Address for Coverage Determinations:

HIP Health Plan of New York
Anticipated and Continuing Service Program
55 Water Street
New York, NY 10041-8190

1-866-447-9717 Prompt 4
TTY- 188-HIP-4TDD (1-888-447-4833)

Exceptions Process

Providers, members or their authorized representative may request an exception to the plan's tiered cost-sharing structure or request coverage of a non-formulary drug.

In order for an exception to be evaluated, the provider must provide supporting documentation that the formulary drug would not be as effective (or has been ineffective) and/or would have adverse effects. Note that certain high cost drugs may not be eligible for the exceptions process. All drugs approved under the exceptions process must meet the definition of a Part D drug. In addition, a provider's statement does not necessarily result in an automatic favorable determination.

Enrollees will be notified of changes to the formulary (including cost sharing changes) as they occur. For changes to the HIP formulary, please go to www.HIP.com

Phone Number and Address for Exceptions Process:

HIP Health Plan of New York
Pharmacy Services
PO Box 1520
JAF Station
New York, NY 10116-1520
Phone: 1-800-HIP-TALK (1-800-447-8255)
TTY: 1-888-HIP-4TDD (1-888-447-4833)

In Person:

HIP Health Plan of New York
Member Access Unit
55 Water Street
New York, NY 10041

Re-determinations

An enrollee who has received an adverse coverage determination may request that it be re-determined. For standard re-determinations, an enrollee or their representative must make written request within 60 calendar days of the notice of the coverage determination denial. This may be extended if the enrollee shows good cause (this must be in writing and give the reason that it was not filed timely). For expedited re-determinations, an enrollee or their prescribing physician may make an oral or written request for coverage. HIP will promptly decide whether to expedite the request.

For a standard re-determination, if the request is granted, HIP will make the determination and give notice within 7 calendar days of receiving the request. If the request is granted in whole or in part, HIP will notify the enrollee in writing within 7 calendar days of receiving request for re-determination. If the request is for payment, payment will be effectuated within 30 calendar days of receiving request. Note that expedited re-determinations are not permitted for payment requests.

For an expedited re-determination, if the request is granted, HIP will make the determination and give notice within 72 hours of receiving the request. If additional medical information is needed, the enrollee and prescribing physician will be notified immediately. If the request for an expedited re-determination is denied, HIP will make the determination within 7 days of the request and give prompt oral notice of the denial to expedite the redetermination request. The denial will (1) explain the standard process; (2) inform the enrollee of the right to file an expedited grievance; (3) inform the enrollee of the right to resubmit the request with the physician's supporting documentation; and (4) provide instructions about HIP's grievance process and its timeframes. We will also send a written notice within 3 calendar days after oral notification of the denial.

Address and Phone Number for Re-determinations:

HIP Health Plan of New York:

Grievance and Appeal Department

P.O. Box 2807

New York, NY 10116-2807

Phone: 1-800-HIP-TALK (1-800-447-8255)

TTY: 1-888-HIP-4TDD (1-888-447-4833)

For additional information about grievances, coverage determinations and re-determinations, please see Section 4 of your Evidence of Coverage.