DEPARTMENT OF HEALTH
BUREAU OF MANAGED CARE
GUIDELINES AND TECHNICAL ADVICE TO HMO APPLICANTS REGARDING MEMBER GRIEVANCE PROCEDURES

The following items must be integrated into the member grievance procedures submitted in the Certificate of Authority application.

1) **Copy of formal grievance procedure language to be included in all subscriber contracts to include:**

"HMO members with complaints should contact the HMO Member Service Department. Each complaint will be promptly investigated and the HMO will provide a member with a response to a complaint within thirty (30) days of receipt. A member dissatisfied with the HMO's handling of a complaint or receiving a claim denial from the HMO may file a formal grievance."

"There are two steps in the HMO grievance process. The initial grievance will be reviewed and investigated by an initial Grievance Committee composed of one or more employees of the HMO. The Committee will provide a written decision within thirty (30) days of its receipt of a grievance, and the written decision will specify the reasons for the decision and a member's appeal rights. The initial Grievance Committee decision will be binding, unless the member appeals the decision. The appeal of the 1st level Grievance Committee shall be to the 2nd level Grievance Review Committee established by the Board of Directors of the HMO. This 2nd level Review Committee will have at least 1/3rd HMO members enrolled in the HMO. The Committee will hold an informal hearing to consider your grievance. You have a right, but are not required to attend. When arranging the hearing, the HMO will notify you in writing of the hearing procedures and your rights at such hearing. The hearing will be held within thirty (30) days of your request to appeal. At any stage in the grievance process, the member has the right to request that the HMO appoint a member of its staff who has had no direct involvement in the case to represent the member. Such assistance may be particularly useful to a member in preparing a succinct, factual, supportable presentation to the Committee at the hearing."

"The 2nd level Grievance Review Committee will issue a formal decision within ten (10) working days of the hearing. This decision will specify the reasons for the Committee's decision, and the decision is binding unless the member appeals the decision to the Pennsylvania Department of Health. The Committee's decision will provide information regarding your rights of appeal to the Department, and its address and phone number."

"In each step of the grievance process, the member should be as specific as possible as to

the remedy being sought by the HMO. Grievances usually deal with claim denials, and the remedy sought is payment of the claim by the HMO. In those cases, however, in which a member believes that serious medical consequences will arise in the near future (week or ten days) from an HMO's failure to provide needed, medically necessary and covered health services, there is a procedure for expedited review. In such a case, the member should identify the particular need for an expedited review to the Member Relations Department. The HMO will arrange to have the grievance reviewed by an HMO Medical Director within forty-eight (48) hours and the Medical Director will inform the member of his decision in writing. If the Medical Director's decision is adverse to the member, the member may appeal the decision immediately to the 2nd level Grievance Review Committee."

"The Bureau of Managed Care in the Pennsylvania Department of Health, Room 1030 Health and Welfare Building, P.O. Box 90, Harrisburg, PA 17108-0090 (1-888-466-2787) is responsible for monitoring HMO compliance with grievance procedures."

2) **Copies of sample generic claim denial letters including: (a) sample claim denial forms/letters routinely used by the HMO amended to include specific reference to member right of appeal under the grievance procedures; (b) sample denial letter issued by the 1st level Grievance Committee containing appropriate language informing the member of his/her right to appeal to the 2nd level Grievance Review Committee; and (c) sample denial letter issued by the 2nd level Grievance Review Committee including language informing the member of the right to appeal to the Department of Health (with DOH address and phone number).**

3) **Copy of standard paragraph/wording to be included in all Medical Director reviews/denials informing the member of his/her rights to appeal a Medical Director and/or utilization review decision to the 2nd level Grievance Review Committee.**

4) **Copy of the HMO applicant's written procedures for holding 2nd level Grievance Review Committee hearings, including a copy of the letter to the member informing him of hearing protocols and rights.**

5) **Copy of the HMO applicant's statement of policy regarding under what conditions the 2nd level Grievance Review Committee proceedings will be: (a) summarized through use of meeting minutes; (b) tape recorded; and (c) transcribed.**

6) **Copy of Board resolution or other evidence by which the Board of Directors has established 2nd level Grievance Review Committee, and a list of subscriber members participating on the 2nd level Grievance Review Committee (or a description of the procedure on how subscribers are selected when needed to serve on a Grievance Review Committee.)**

"RESOLVED, that the Board of Directors approve the formation of a 2nd level Grievance Review Committee.

FURTHER RESOLVED, that other appointments may be made to the 2nd level Grievance Review Committee, on a case-by-case basis, when appropriate, to afford members a fair hearing, but in all cases, there shall be maintained at least 1/3rd subscriber representation.

FURTHER RESOLVED, that, for those cases where Expedited Review decisions are appealed, an Expedited Review Grievance Committee composed of those who have not been previously involved in said decisions, shall be convened to hear the case as soon as possible."

7) **Copy of the HMO applicant's procedure for expediting grievances for medically pressing issues.**

An HMO may not use the timeframe or procedures of the HMO grievance process to avoid the medical decision process or to discourage or prevent the member from receiving medically necessary care in a timely manner. When the dispute is recognized by the HMO or the member as involving care which is alleged to be medically necessary and pressing, but not yet rendered, the HMO must render a written decision within a reasonable time (48 hours). This decision must be signed by the Medical Director. If the member appeals this decision, the review may begin at the 2nd level and does not have to be re-heard by an internal committee of staff. Moreover, the availability of this expedited review process must be made known to all members in all written descriptions of the grievance process. If a member contacts the Department directly, Department staff will immediately contact the Plan and request an expedited review of the case by the Plan's Medical Director.

Pennsylvania Department of Health

HMO Grievance Systems
Operational Standards for Fundamental Fairness for HMO Members

(August 1, 1991 Publication)

I. Introduction

The Pennsylvania Department of Health has developed HMO Grievance Systems Operational Standards and is providing this explanation of its standards in order to:

- Assist health maintenance organizations (HMOs) in the Commonwealth to comply with provisions of the Health Maintenance Organization Act and Department of Health Regulations (28 PA Code Chapter 9);

- Help ensure that the HMO member receives a fundamentally fair process for resolving grievances;

- Maximize the use by a member of internal HMO grievance systems and procedures before involving regulatory agencies;

- Maximize thorough investigation and documentation of substantive issues regarding a member grievance by HMOs themselves, so as to ensure creation of adequate records upon which appeals to the Department by an HMO member may be judged;

- Minimize the potential for the Department overturning HMO second level Grievance Review Committee (as specified in 9.73(s)) decisions based on failure to follow proper administrative procedures, and/or to provide adequate fundamentally fair grievance resolution;

- Develop and promote uniformity in the reporting of grievances to enhance the potential for tracking trends and comparative analysis of grievance resolution and member satisfaction not only the Department but by purchases and consumers of HMO services; and

- Ensure prompt expedited review by the HMO and the Department of grievances alleging HMO denial of urgently needed care.

Each licensed HMO is to submit for Department review and approval, member grievance resolution procedures complying with the provisions of the HMO Act and Regulations as well as Department expectations regarding compliance set forth herein.

II. Background

During the course of the external quality review process, Department staff identified many deficiencies in the methods by which HMOs define, process, and resolve disputes with their members. The Department identified the need for improvement plans of many HMOs.

In many of our meetings with HMO CEOs, Medical Directors and other staff to discuss preliminary quality improvement plans and short-term quality assurance work plans, the Department indicated that it was working on a uniform set of grievance guidelines/operational procedures, and would be distributing them in the near future.

In addition, the Department recently has been receiving an increasing number of appeals of HMO members from the decisions of HMO second level Grievance Committee determinations. We could not help but notice in reviewing the files/records underlying these grievance appeals, various significant deficiencies in HMO grievance procedures.

For example, we found such deficiencies as:

1) A record which included three separate claim denial letters from the HMO, including one signed by the HMO Medical Director. None of the denial letters mentioned the grievance process or the member's right to appeal an adverse decision. When the member wrote to the Department for assistance, the indication was that all appeals within the HMO had been exhausted. Yet, upon contacting the HMO, despite the fact that the claim had been more than nine months old and had been formally denied three times, the HMO initially argued that the member would have to go back to the first level Grievance Committee Review, since a formal grievance had never been filed.

2) Second level Grievance Review Committee decisions by committees not containing the one third subscriber member representation required by the Department's regulations, and containing HMO staff member who had previously denied the grievance at the first level.

3) Decisions which are not clearly supported by specific findings on critical substantive issues in dispute. For example, a recorded two sentence decision and summary of a second level Grievance Review Committee's determination that a grievance regarding payment of an out-of-plan emergency claim was upheld because the member failed to obtain approval of the primary care physician (PCP), with absolutely no consideration in the record of the critical substantive issue of whether or not a true emergency may have existed.

The Department hopes that by issuing this in-depth clarification of its expectations in the form of operational standards, fewer member appeals from HMO second level Grievance Review Committee decisions will be questioned on fundamental fairness/due process grounds, and that the grievance records furnished to us as part of the appeal process will address all of the important and essential substantive issues involved in each grievance. Grievance decisions which afford fundamental fairness/due process and which adequately address all substantive issues involved will be beneficial to all parties concerned: the HMO, the HMO member, and the Department.

III. Definitions, Reporting and Member Notification of Grievance Rights

The Department's quarterly and annual HMO reports require submission of statistics on grievances. Section IV of the quarterly report, "Grievance Data", states: "List the number of formal grievances filed with the plan this quarter. Attach a brief summary of each."

It is the Department's intent and you are hereby advised to change Section IV of the quarterly report to require reporting of four (4) statistics:

1) List number of first level grievances filed with the plan this quarter: _______

2) List number of first level grievance decisions by the plan this quarter: _______

   a) Number decided in favor of member: _______
   b) Number upholding HMO's position: _______

3) List number of second level grievances[1] filed with/appealed to the Plan's second level Grievance Review Committee consisting of at least one third subscriber members this quarter: _______

4) List number of second level grievance decisions by the plan this quarter: _______

   a) Number decided in favor of member: _______
   b) Number upholding HMO's position: _______

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[1]. Based on 28 PA Code Chapter 9, Section 9.97 Exceptions: With the required Department of Health approval, a plan may choose to limit its grievance system to one level. Be advised that if this option is elected, the composition of the Committee must be the same as for a second level Grievance Committee, i.e., one third subscriber members. In addition, all procedures governing second level Grievance Committee review must be adhered to and the option must be consistently utilized. An HMO choosing this option must request approval from the Department prior to implementation.

HMOs, in reporting these statistics, should utilize the definitions contained below. It is the Department's intent during its periodic on-site visits to review the complaint log and files of complaints, and to review first and second level grievances to ensure proper classification and handling.

To provide HMOs with sufficient time to revise internal reporting procedures, this change in reporting grievance data will be effective for the fourth quarter of 1991, October-December.

Inquiry: An inquiry is any member's request for administrative service, or information, or to express an opinion. Whenever specific corrective action is requested by the member, or determined to be necessary by the HMO, it should be classified as a complaint.

Complaint: A complaint is an issue a member presents to the HMO, either in written or oral form, which is subject to informal resolution by the HMO within a thirty-day period. All HMOs must establish and maintain an effective complaint resolution system, including a written log of each complaint and its disposition. Failure to render a decision within the thirty-day timeframe automatically results in the complaint being upgraded to a grievance.

Grievance: A grievance is a complaint which cannot be resolved to the member's satisfaction or when the member requires formal grievance consideration during the thirty-day period. All grievances shall be committed to written form either by the member or the HMO prior to processing.

DOH Expectations Regarding Complaints and Inquiries:
Each HMO must maintain written documentation on all such phone calls or letters classifying them by type in a complaint and/or grievance log for assuring timely resolution of all complaints and grievances.

Each HMO also must ensure an appropriate referral process for concurrent medical service issues as described herein. The HMO should adopt a policy to routinely advise dissatisfied members of their right under the complaint/grievance system over the telephone and advise them how to file a written grievance. Members must be informed of their rights under the grievance process (in writing) at each point in which a potential dispute regarding claim denial is identified by an HMO.

Each HMO must establish a reasonable timeframe for informal resolution. Such reasonable timeframe appears to be thirty (30) days for all non-medically pressing retrospective issues or disputes. Medically pressing concurrent issues require a different approach and the grievance procedure may not be used as a barrier to needed care.

Such disclosures will assist HMOs, since fully informed members are likely to use the proper grievance procedures rather than contact regulatory authorities directly with matters which

should properly be handled within the HMO's grievance process. Regulatory consideration is reserved as the last step in the grievance process.

The Department has noted that many HMOs are not specific in their disclosures to members. For example, general references in claim denials, such as "if you have a question concerning this claim denial, call us" or "refer to your subscriber contract if you have any questions" are insufficient. References should be specific to the grievance process, for example: "If you are dissatisfied with this claim denial, you should call member services. Member services will then attempt to informally resolve the matter. If the matter has not been resolved to your satisfaction in thirty (30) days, you may then file a formal grievance with the Plan."

Since deficiencies have been noted in this area, HMOs should ensure that all letters from the Medical Director and/or quality assurance/utilization review departments denying coverage, also contain notification of the grievance process. For example, a letter from a Medical Director to a subscriber, stating that he/she has reviewed the applicable medical records and determined that the care provided was not medically necessary or not a true emergency, should contain a clear notification that the member has a right to contact the Plan for informal resolution or to file a formal grievance. (See **Exhibit 2**)

The process of routine claim review does not constitute a first-level grievance review as it is generally an administrative process that may occur off-site and often occurs apart from the medical and management decision process. For example, a missing piece of information may often be the basis for claim denial. The grievance process is an administrative procedure that requires a higher level of detail and objectivity.

IV. Department Expectations Regarding Fundamental Fairness at the First Level Grievance Review

The first level Grievance Review Committee is to be made up of one or more employees of the HMO (Medical Director, Q.A. staff, etc.) The Committee should not include any person whose decision is being appealed or who made the initial determination denying a claim or handling a complaint. This first level grievance review may be in the form of a phone conference, staff meeting, or polling of experts by telephone. The first level grievance review should be held within thirty (30) days of receipt of the grievance.

We recommend that, whenever possible, the HMO afford the member the opportunity to present his case, but the member <u>does not</u> have the right to attend or to have representation in attendance at this stage. The member does have the right to submit written material and to have an uninvolved staff person assist him, and the HMO has the obligation to assure that these rights are made known.

Official record of the review is not necessary by the HMO with the exception of issuance of a

written decision, at the earliest possible time following the hearing, but not more than ten (10) working days after the date of the hearing. In addition, a record of those persons participating in the decision must be maintained. In all cases where the member is not upheld completely, and the possibility exists of the member going to the second level grievance review, the content of the written decision is most important and must contain:

1) Description of committee's understanding of member's grievance as presented to the grievance committee, e.g., dollar amount of the disputed issue, medical facts in dispute, etc.;

2) Committee's decision in clear terms and the contract basis or medical rationale in sufficient detail for member to respond further to HMO's position, e.g., did not contact PCP, non-emergency service as identified in the medical record, or not covered by subscriber contract;

3) Evidence or documentation used as the basis for the decision should be referenced in the letter, e.g., Paragraph 1.1 of subscriber agreement, ambulatory records, etc.; and

4) Statement indicating:
   a) decision is binding unless the member appeals to the second level;
   b) a description of the process on exactly how to appeal to the second level Grievance Review Committee; and
   c) the written procedures governing appeal including any required timeframe for appeal.

The HMO should provide a minimum of thirty (30) days to appeal and such timeframes should not exceed sixty (60) days unless there are extenuating circumstances.

Upon receipt of a request of an appeal to the second level grievance review committee, the HMO shall provide the member requesting the appeal, a brief disclosure of procedures regarding the appeal and hearing. A sample disclosure is attached in **Exhibit 1**.

As stated in Section III, a plan may choose to limit its grievance system to one level based on 28 Pa Code Section 9.97 Exceptions, provided the procedures governing the second level Grievance Committee reviews are utilized and the required approval by the Department of Health is obtained prior to implementation.

V. Department Expectations Regarding Fundamental Fairness at the

Second Level Grievance Review

The second level review is to be conducted by a committee, one third of which must be actual HMO members appointed by the Board of Directors of the HMO. The Department recommends that subscriber board members serve as the required subscriber members on the grievance committee. This committee may not include anyone previously involved in the grievance. For example, the Medical Director or member services supervisor, unless they have had no prior involvement in the case, should not serve on the Committee. Committee members must have the ability to be fair and impartial. Moreover, it is the Department's suggestion that there be some continuity of HMO Grievance Committee membership so as to facilitate a knowledgeable and consistent approach to grievance resolution.

The Committee must have written procedures approved by the Department for investigating and conducting hearings relative to second level grievances. The procedures shall include general provisions regarding member rights as well as specifics concerning the HMO's responsibilities in assuring due process and the steps to be taken in that regard. At a minimum, the procedures must include:

General Provisions Regarding Member Rights:

1) The member always has a right to attend the second-level hearing and to present his or her case, and has the right to be assisted/represented by a person of his or her choice.

2) The member may again submit written material in support of his or her claim. Formal rules of evidence are not appropriate, and the member may arrange for a physician or other expert to testify on his behalf.

3) The member has the right to question HMO staff concerning the dispute.

4) The member's right to a fair and equitable hearing may not be made conditional on his/her appearance at the hearing. Regardless of the member's presence or lack thereof, the hearing must be conducted in the same manner.

5) The HMO is responsible for insuring that hearings are held at mutually convenient times. The member shall be notified in writing, at least fifteen (15) days in advance, of the date and time of the hearing, which should be held within thirty (30) days of receipt of the appeal. Requests for hearing postponement by a member (for just cause) must be considered.

6) The member shall receive a description of the Committee's procedures so as to permit him or her to be prepared for the hearing.

7) The member should also be re-advised of his/her right to have a non-involved staff person to assist him/her in preparing for the grievance hearing.

Provisions Regarding the Hearing Process.

1) The written decision of the first level Grievance Review Committee shall be the basis for deliberation. The objective is to keep the hearing informal and impartial so as not to be intimidating to the member.

2) Matters brought before the Grievance Committee should not be discussed by the Committee prior to the meeting.

3) Committee members should be introduced to the HMO member filing the appeal, and there should be clear identification of the subscriber member and HMO staff serving on the Committee.

4) There should be a clear recognition on the part of all members of the Committee, subscriber members, and HMO staff alike, that their responsibility is to impartially hear and consider the dispute based solely on the material and presentations made during the hearing.

5) If an attorney representing the HMO is present at the hearing, the primary purpose of the attorney should be to represent the interests of the impartial Grievance Review Committee in insuring that a fundamentally fair hearing takes place and all issues in dispute are adequately addressed. The attorney should not argue or represent the HMO staff positions in the dispute.

6) If the HMO desires to have an attorney present to represent the interests of the HMO staff, it also must make available an attorney to represent and assist the Grievance Committee.

7) Written minutes or a tape recorded record of the second level hearing is required. A verbatim transcript is optional, but desirable from the Department's position, particularly for those cases likely to be the subject of further appeal. The lack of complete documentation of evidence presented, may create the need to hold additional hearings at the Department level or increase the possibility of the Department ordering the case to be re-heard. It is strongly recommended that dispute of cases involving substantial funds (more than $ 5,000) have a written transcript prepared.

8) A member of the HMO staff previously involved in and knowledgeable about the grievance should present and summarize for the Committee, the HMO staff's rationale for recommending that the denial be affirmed by the second level Grievance Committee.

9) The Committee should be permitted to ask questions of the HMO staff.

10) The HMO member or his representative should be given the right to present his side of

the dispute, and ask questions of the HMO staff person(s) presenting the HMO side of the dispute.

11) The Committee must render a decision no more than ten (10) working days following the Grievance Committee meeting.

12) The member must be advised, in writing, of the outcome of the Committee's deliberation. The written notice shall contain:

(a) a statement of the Committee's understanding of the nature of the grievance and all pertinent facts;

(b) committee's decision and rationale;

(c) evidence of documentation supporting such conclusions; and

(d) a statement of the member's right to appeal to the Department of Health with the phone number and complete address of the Department. The address and phone number to be used are:

Bureau of Managed Care
Pennsylvania Department of Health
Room 1030 Health & Welfare Building
P.O. Box 90
Harrisburg, PA 17108-0090
Phone: 717-787-5193

Appeals to the Department of Health should be filed by the member within thirty (30) days of the notification to the member of the decision unless extenuating circumstances are involved.

NOTE: 28 PA Code Chapter 9, Section 9.73, "subscriber grievance systems," indicates that second level appeals may be made to either the Insurance Department or Department of Health, depending upon the nature of the grievance." The Department of Health has coordinated with the Insurance Department, and the Departments have agreed that all grievance appeals **should go to the Department of Health**. (Based upon experience, the vast majority of appeals deal with medical necessity or medical management issues appropriate to the Department of Health, rather than to pure contract interpretation issues). The Department of Health will review the appeal, and seek appropriate opinion/advice from the Insurance Department on issues which warrant Insurance Department input.

HMOs should immediately revise second level grievance decisions to include only the name, address and phone number of the Department of Health. Within one (1) year, or the

next time subscriber contracts are amended, all grievance procedure descriptions contained in HMO subscriber contracts should be amended to include reference only to the Department of Health.

SPECIAL NOTE: It is particularly important that the second level Grievance Review Committee carefully consider and make particular findings of fact on all key factual disputes. For example, if the grievance involves a factual dispute between a member and a primary care physician (PCP), the Grievance Committee should not automatically assume that the physician is correct and the member is incorrect. The Committee has a responsibility to carefully weigh the accounts of both physician and member, and make an independent judgement on whose account is more credible.

For example: Assume the grievance involves payment of an out-of-plan emergency which the Plan has previously rejected because the member did not first contact his/her PCP and because the condition, in the opinion of the HMO, was not a true emergency. The claim was denied on the basis of the Medical Director's judgement that a true emergency did not exist. The member presents a letter from the admitting physician justifying why he/she believed the condition warranted emergency treatment. It is insufficient for the second level Grievance Review Committee to automatically assume the HMO Medical Director is correct and the other physician is incorrect. The Committee must make an independent assessment and include in its findings of fact, which physician's judgement it chose to accept and why.

VI. Department Hearings

The Department may at its discretion, particularly in those cases in which the formal grievance record submitted by an HMO is insufficient or inadequate, order the HMO to re-hear the grievance and address specific ambiguities in the record. Alternatively, the Department may hold its own hearing and gather independent testimony on the grievance from the HMO, member and other applicable parties.

VII. Department Expectations Regarding Fundamental Fairness in Promptly Reviewing Medically Pressing Issues

An HMO may not use the timeframe or procedures of the HMO grievance process to avoid the medical decision process or to discourage or prevent the member from receiving medically necessary care in a timely manner. When the dispute is recognized by the HMO or the member as involving care which is alleged to be medically necessary and pressing, but not yet rendered, the HMO must render a written decision within a reasonable time (48 hours). This decision must be signed by the Medical Director. If the member appeals this decision, the review may begin at the second level, and does not have to be re-heard by an internal committee of staff. Moreover.the availability of this expedited review process must be made known to all members in all written descriptions of the grievance process.

If a member contacts the Department directly, Department staff will immediately contact the Plan and request an expedited review of the case by the Plan's Medical Director.

VIII. Grievance Rights of Select Subgroups of Members, Including Federal Employees, Medicare Risk Contract Members, and Medicaid Members

The Department is currently in the process of researching potential conflicts between special grievance procedures which may be applicable to each of these special groups, versus Pennsylvania specific requirements.

Supplemental instructions will be issued at a later date. HMOs should continue to handle grievances for these members as they currently do.

The Department's preference is that there be one uniform grievance process, complying with these expectations, applicable to all HMO members, and any difference in handling of appeal rights occur only at the end of the Pennsylvania specified grievance procedures. After the Department of Health has made determination on a second level grievance appeal.

IX. Special Procedures for Involuntary Disenrollment

Because of the infrequent, and serious nature of involuntary disenrollment of a member by an HMO, no such involuntary disenrollment shall occur without an HMO first providing a member so affected with adequate opportunity to utilize the grievance system to contest the disenrollment. If the member contests the disenrollment through the grievance process and appeals the decision of the second level Grievance Committee to the Department, the disenrollment shall not be effectuated until the Department has issued a decision on the appeal. The one exception to this requirement is if there is adequate documentation that the member poses a serious threat to the safety of the HMO and/or its providers, and the HMO finds that immediate disenrollment is necessary for its protection and/or the protection of its staff and providers. In such cases, a disenrolled member shall still be entitled to use the grievance mechanism to challenge his/her disenrollment.

X. Grievance Reporting

The Department expects that any grievance identified by an HMO will be the basis for quarterly and annual reporting to the DOH. Complaints and inquiries should be maintained for tracking purposes, but these incidents are not to be reported to the Department of Health. First and second level grievances should be identified and reported to the Department on a quarterly basis, pursuant to the instructions contained herein.

Finally, a patient's confidentiality should also be considered when reporting grievance information to the Department in quarterly and annual reports, which are considered public

documents. Patient codes rather than names should appear in these reports

XI. Miscellaneous Overview

In conclusion, more specific information is presented in a question/answer format regarding grievance administration to reinforce some o the major points presented.

QUESTION: Is s phone call complaining about inability to get referral or inability to reach PCP a complaint, a grievance or simply a phone inquiry?

ANSWER: It is a complaint - it does not immediately become a grievance until it is not resolved by the HMO during an initial thirty-day period or unless the member requests formal consideration of a grievance. However, if the matter cannot be resolved to the member's satisfaction within thirty (30) days, the HMO must assist the member, if requested, by completing a grievance form, taking all necessary information over the phone and initiating the grievance review process. The HMO may choose the option of sending the member a grievance form to complete, in order to access the HMO grievance system. At the time of the HMO's contact with the member, the HMO shall describe the grievance process and procedures including the member's right to have a non-involved HMO staff member assist them and their right to submit written documentation relevant to the dispute.

QUESTION: Must all complaints that are received in writing be considered a grievance?

ANSWER: No, if it can be <u>resolved</u> to the member's satisfaction by staff informally, it is not a grievance, even tough it is received in writing. Complaint logs should clearly indicate when a complaint has been received/resolved. Grievance forms should be mailed to the member automatically at the end of the thirty (30) day period or in those instances where the complaint has not been resolved to the member's complete satisfaction.

QUESTION: Are all written or telephone complaints concerning denied claims automatically considered a grievance?

ANSWER: Not necessarily, if for example, the member's claim needs further research, this can be accomplished under the complaint definition. If, however, after thirty (30) days of additional research, the matter is not resolved and the member is still dissatisfied, the member must always be afforded the opportunity to file a grievance.

Further, if due to the circumstances at hand, it is determined that additional informal review will not be productive, then the matter shall immediately be

considered a grievance at the member's request or at the HMO's determination. At all times, a member has a right to the formal grievance system and the HMO may not require an informal period of attempted resolution unless the member agrees. At the point where a complaint is considered unresolvable, when thirty (30) days elapse or when the member so requests a grievance, that is the point when all such matters should be identified and treated by the HMO as a formal grievance.

XII. Description of Grievance Procedures to Appear in Subscriber Contracts

One of the problems the Department has identified is the large variability on the structure and content of grievance descriptions. While the Department of Health is responsible for group subscriber contracts and certificates, which are subject to approval by the Insurance Department, apparently some HMOs make changes in the grievance procedure descriptions in the subscriber contracts without obtaining prior approval from the Department of Health.

To help ensure compliance with Department requirements, an acceptable grievance procedure description has been prepared and is attached as **Exhibit 3**. HMOs using this standard description in filed subscriber contracts will receive prompt review and approval by the Insurance Department. Any deviation however, will not be approved by the Insurance Department until the Department of Health has first reviewed and approved the proposed changes.

Each submission for approval of descriptions of grievance procedures which deviate from the attached example must contain a detailed explanation of the HMO applicant's reasons for the proposed deviation as well as a description on how the deviation will serve to improve fundamentally fair processing of member grievances.

HMOs also are reminded of their responsibilities at least once a year to provide members with a separate and additional notification of their rights under the grievance system. This is generally accomplished through publication in the HMO newsletter.

XIII. Filing Requirements

Each licensed HMO, not later than the date specified in the cover letter accompanying this document, shall submit to the Department, member grievance procedures which address these operational standards. Included in this submission should be:

1) Copy of formal grievance procedure language to be included in all subscriber contracts. Currently used grievance procedure language in subscriber contracts should be reviewed and revised to comply with the operational standards and the example contained in **Exhibit 3.**

2) Copies of sample generic claim denial letters, for example:

a) Sample claim denial forms/letters routinely used by the HMO amended to include specific reference to member right of appeal under the grievance procedures;

b) Sample denial letter issued by the First Level Grievance Committee containing appropriate language informing the member of his/her right to appeal to the Second Level Review Committee; and

c) Sample denial letter issued by the Second Level Grievance Review Committee including language informing the member of the right to appeal to the Department of Health (with DOH address and phone number).

3) Copy of standard paragraph/wording to be included in all Medical Director reviews/denials and all utilization review denials, informing the member of his rights to appeal a Medical Director and/or utilization review decision to the second level Grievance Review Committee;

4) Copy of the Plan's written procedures for holding second level Grievance Committee Review hearings, including a copy of the letter to the member informing him/her of hearing protocols and rights;

5) Copy of the Plan's statement of policy regarding under what conditions the second level Grievance Review Committee proceedings will be: (1) summarized through use of meeting minutes; (2) tape recorded; and (3) transcribed.

6) Copy of Board resolution or other evidence by which the Board of Directors has established second level Grievance Review Committee, and a list of subscriber members participating on the second level Grievance Review Committee (or description of the procedure on how subscribers are selected when needed to serve on a Grievance Review Committee.) See **Exhibit 4**.

7) Copy of the Plan's procedure for expediting grievances for medically pressing issues - see section VII of this document.

EXHIBIT 1

Sample Disclosure Form for Members Appealing

a Negative Decision by the First Level Grievance Committee to the Second Level Grievance Committee

Subject: **Procedure at the Second Level Grievance Committee Hearing**

To: **Member Requesting Appeal of Grievance**

1) You have appealed the initial denial of your grievance to the Plan's Second Level Grievance Review Committee. This committee has been appointed by the HMO Board of Directors, and contains a minimum of 1/3rd subscriber members.

2) The Committee will hold an informal hearing to review your appeal. You have the right to appear at the hearing and present your views on the grievance, although you are not required to attend. If you wish, you may submit additional written comments or clarification regarding your case to the Grievance Committee, in lieu of attending the hearing. You may bring with you persons who may clarify the grievance. For example, a member appealing a denial of an emergency claim by the Plan based on its assessment that a true emergency did not exist, may wish to arrange for the physician who provided the care to be present and explain his/her judgement of why he or she believed that an emergency existed or to submit a written statement on your behalf.

3) A copy of all material being furnished to the Grievance Committee regarding your grievance will be furnished to you upon your request. You may submit additional comments regarding the material to the Committee in advance of the hearing, or if necessary, at the hearing itself

4) If you want an impartial member of the HMO staff to assist you in presenting your case to the Grievance Committee, please contact us.

5) The hearing will be informal. Minutes of the meeting, tape recording of the meeting, and/or verbatim transcript may be taken. This is done to ensure an adequate record is established for forwarding to the Department of Health, if you are displeased with the decision of the Grievance Committee and exercise your right to appeal its decision to the Department.

6) When you go before the Grievance Committee, you will be introduced to the Committee, and members of the Committee will be introduced to you. A representative of the Plan will summarize your grievance, prior actions taken on it, and give the Plan's staff reasons for continued denial on the grievance. The Committee may question the Plan representative. You will then be given an opportunity to make a presentation to the

Committee. Your comments should be brief and to the point. You should be clear and specific in giving reasons why you believe the Plan's decision is in error. After your presentation, you may ask questions of the HMO staff person who presented the HMO's case to the Committee. The Committee may then ask questions of you. At the conclusion of your hearing, you may leave and the Committee will furnish you with its written decision within ten (10) working days.

7) You do have the right to have an attorney come with you and represent you at the hearing. If you do so, however, you must inform the Plan at least five (5) working days in advance, so that the Committee may have the opportunity of having its own legal representation available. Remember, however, that this will be an informal hearing, with no formal rights of examination and cross-examination. Please do not feel intimidated or reluctant to appear before the Committee and present your side of the grievance.

8) For additional information, or if you have any questions, please contact:

Member Services Department
(HMO name and address)
(Phone and fax numbers)

EXHIBIT 2
Sample Letter from Medical Director*
Containing Adequate Disclosure

Dear _______:

Your request for review of the Plan's denial of your claim for emergency services rendered on [date] at a non-participating hospital has been referred to me as the Plan Medical Director.

I have reviewed the medical records of the non-participating hospital regrading your emergency room visit, and determined that the records contain no documentation that the treatment you sought was for a true emergency as defined in the Plan's subscriber contracts.

Your condition was such that a delay in contacting your primary care physician, as required by Plan rules, would not have resulted in serious medical consequences. Thus, the Plan continues to deny your claim.

You have the right to appeal this decision to the Plan's 2nd level Grievance Review Committee. If you wish to do so, contact member services at [telephone number] for information on the procedure to use to initiate this appeal

Sincerely,

(Medical Director)

*<u>NOTE:</u> In this sample case, it is apparent that the emergency room claim was initially denied, and that the member appealed the denial. This letter from the Medical Director constitutes, in effect, a first level grievance review. Thus, the appeal should be directed to the 2nd level Grievance Review Committee. It would be fundamentally unfair, in this sample case, for the Medical Director (considering his letter would constitute a 2nd denial by the Plan) to require the HMO member to start at the 1st Grievance level. Even if the member failed to formalize his request to the Plan to reconsider its claim denial, the request should be considered a grievance, and an appeal should go to the 2nd level Grievance Review Committee.

EXHIBIT 3
Sample Grievance Procedures Acceptable for Use by HMOs in Subscriber Contracts

Under the provisions of the Pennsylvania HMO Act and Department of Health regulations, (HMO name) has established the following grievance procedures for use by members in any way dissatisfied with the HMO or participating provider.

HMO members with complaints should contact the HMO Member Service Department. Each complaint will be promptly investigated and the HMO will provide a member with a response to a complaint within thirty (30) days of receipt.

A member dissatisfied with the HMO's handling of a complaint or receiving a claim denial from the HMO, may file a formal grievance.

There are two steps in the HMO grievance process.

The initial grievance will be reviewed and investigated by an initial Grievance Committee composed of one or more employees of the HMO. The Committee will provide a written decision within thirty (30) days of its receipt of a grievance, and the written decision will specify the reasons for the decision and a member's appeal rights.

The initial Grievance Committee decision will be binding, unless the member appeals the decision.

The appeal of the 1st level Grievance Committee shall be to the 2nd Level Grievance Review Committee established by the Board of Directors of the HMO. At least 1/3rd of the 2nd level Grievance Review Committee members must be HMO members enrolled in the HMO.

The Committee will hold an informal hearing to consider your grievance. You have a right, but are not required to attend. When arranging the hearing, the HMO will notify you in writing of the hearing procedures and your rights at such hearing. The hearing will be held within thirty (30) days of your request to appeal.

At any stage of the grievance process, the member has the right to request that the HMO appoint a member of its staff who has had no direct involvement in the case to represent the member. Such assistance may be particularly useful to a member in preparing a succinct, factual, supportable presentation to the Committee at the hearing.

The 2nd Level Grievance Review Committee will issue a formal decision within ten (10) working days of the hearing. This decision will specify the reasons for the Committee's decision, and the decision is binding unless the member appeals the decision to the Pennsylvania

Department of Health. The Committee's decision will provide information regarding your rights of appeal to the Department, and its address and phone number.

In each step of the grievance process, the member should be as specific as possible as to the remedy being sought from the HMO.

Grievances usually deal with claim denials, and the remedy sought is payment of the claim by the HMO. In those cases, however, in which a member believes that serious medical consequences will arise in the near future (week or ten days) from an HMO's failure to provide needed, medically necessary and covered health services, there is a procedure for expedited review.

In such a case, the member should identify the particular need for an expedited review to the Member Relations Department. The HMO will arrange to have the grievance reviewed by an HMO Medical Director within forty-eight (48) hours and the Medical Director will inform the Member of his decision in writing.

If the Medical Director's decision is adverse to the member, the member may appeal the decision immediately to the 2nd level Grievance Review Committee.

The Bureau of Managed Care in the Pennsylvania Department of Health, Room 1030 Health & Welfare Building, P.O. Box 90, Harrisburg, PA 17108-0090 (717-787-5193) is responsible for monitoring HMO compliance with grievance procedures.

Pennsylvania Department of Health

Bureau of Managed Care
HMO Grievance Systems
(May 14, 1992 Publication)

Grievance Procedure Standards
Involuntary Termination of Members

It has come to our attention that HMOs may still be involuntarily terminating members without obtaining the necessary prior approval of the Department of Health.

In a letter dated August 12, 1991, the Department of Health distributed to all licensed HMOs, new Operational Standards for HMO Grievance Systems.

Section IX, "Special Procedures for Involuntary Enrollment," reads as follows:

> "Because of the infrequent, and serious nature of involuntary disenrollment of a member by an HMO, no such involuntary disenrollment shall occur without an HMO first providing a member so affected with adequate opportunity to utilize the grievance system to contest the disenrollment. If the member contests the disenrollment through the grievance process and appeals the decision of the second level Grievance Committee to the Department, the disenrollment shall not be effectuated until the Department has issued a decision on the appeal. The one exception to this requirement is if there is adequate documentation that the member poses a serious threat to the safety of the HMO and/or its providers, and the HMO finds that immediate disenrollment is necessary for its protection and/or the protection of its staff and providers. In such cases, a disenrolled member shall still be entitled to use the grievance mechanism to challenge his/her disenrollment" (Emphasis added)

You should immediately review your internal grievance process and member termination procedures to ensure that in the unlikely event you find it necessary to involuntarily terminate a member, proper procedures are followed.

The procedures to be followed when an HMO desires to terminate a member are:

1. The member is notified of intent to terminate and opportunity to utilize the grievance system to contest the termination. If the member does not exercise his/her right to contest the termination via the grievance system, the HMO may immediately request approval of the termination from the Department of Health. The request should include

EXHIBIT 4

Board Resolution
Appointment of Second Level Grievance Committee

RESOLVED, that the Board of Directors approve the formation of a Second Level Grievance Committee.

FURTHER RESOLVED, that the Second Level Grievance Committee be composed of:

FURTHER RESOLVED, that other appointments may be made to the Second Level Grievance Committee, on a case-by-case basis, when there shall be maintained at least 1/3rd subscriber representation.

FURTHER RESOLVED, that for those cases where Expedited Review decisions are appealed, an Expedited Review Grievance Committee, composed of: ________________, who have not been previously involved in said decisions, shall be convened to hear the cases as soon as possible.

documentation describing in detail the reason for the termination. Upon receipt of Department of Health approval, the member may be terminated.

2. If the member chooses to exercise his/her rights to utilize the grievance system to contest the proposed termination, the second level Grievance Committee ultimately will make a decision and inform the member of his/her right to appeal to the Department of Health. If the member exercises that right, transcript of the hearing and all other applicable information should be provided to the Department. The Department will review the material and issue a written decision. If the decision upholds the HMO, the HMO may then terminate the member.

3. In the unusual event that the member is a threat to the HMO, its staff or providers, an expedited request to the Department should occur. The HMO should fax the request to immediately terminate the member to the Department of Health with its justification for such drastic action. The Department of Health will give an expedited review, and the HMO may then immediately terminate the member upon receipt of the results of the DOH's expedited review and termination approval. The termination notice, however, shall specify the member's right to appeal the expedites termination through the grievance system. If the former member chooses to utilize the grievance system to contest the termination, usual and customary procedures should be followed, including opportunity for hearing and eventual appeal to the Department of Health.

You will note that the key concept is <u>no person should be involuntarily terminated without prior approval of the Department of Health.</u>

If you have any questions, please contact the Bureau of Managed Care (717-787-5193).

Pennsylvania Department of Health

Bureau of Managed Care
HMO Grievance Systems

(June 7, 1994 Publication)

Grievance Procedures and Issues

I. Introduction

This memo supplements the August 1, 1991 publication, "Pennsylvania Department of Health HMO Grievance Systems - Operational Standards for Fundamental Fairness for HMO Members" and our May 1992 letter entitled, "Grievance Procedure Standards for Involuntary Termination of Members." This memo deals with several significant issues which have arisen from the Department's review and determination of HMO member grievance appeals.

II. Issue #1 - Disclosure of Provider Referral Restrictions

The Department of Health recently received a grievance from an HMO member who was unreasonably refused a referral to an alternative specialist group. In this situation, the HMO had a capitation arrangement with a specialty group to handle all orthopedic referrals from a particular primary care group/center. The HMO member had prior experience with this orthopedic group and had complained of quality of service problems. The HMO refused the member's request to be referred to another participating orthopedic group and indicated that the only way the member could obtain access to another participating orthopedic physician was to change his primary care physician practice designation to a primary care physician or group which had no capitated arrangements with specialists and which was, therefore free to make referrals to any participating specialty practice.

The member filed a grievance as a matter of principal, contending that he was quite satisfied with his primary care physician and did not understand why the only way he could obtain access to a different specialty group was to change primary care physicians. The Department upheld this grievance since this specific exclusive specialty referral arrangement had not been disclosed to members in the particular PCP practice/group prior to enrollment.

HMOs should be aware of the Department's expectation that if HMO members' use of specialty providers or hospitals is restricted in any way due to "special" arrangements (such as capitation contracts), these referral restrictions must be adequately disclosed to members in advance. The appropriate place for disclosure of such arrangements is the provider directory given to HMO members to make their selection of primary care physician practices. You are also reminded that all provider contracts, including specialist capitation arrangements, should be filed with the Department for approval prior to use.

III. Issue #2 - Written Transcripts and Adequacy of Grievance Committee Findings

The Department is receiving many grievance appeals involving factual disputes in which the

HMO Grievance Committee failed to adequately address its reasons for accepting one version (usually the HMO staff's) of a disputed fact over another's (the member's).

For example, if a member alleges that he called his PCP's office and obtained verbal approval to go to the ER, and the PCP's office indicates that "it has no record of" having received such a call, there is a factual dispute. The HMO Grievance Committee, in its deliberations and in its written decision, must specifically address what factors led it to conclude that one version of the factual dispute was more credible than the other. The burden of proof does not lie solely with the consumer in such circumstances.

In addition, whenever the HMO Grievance Committee receives evidence from the member, the member's primary care physician, or other participating or non-participating physicians, the Committee cannot simply ignore such information. The record must reflect specific consideration of all such information and the reasons for the Committee's rejection of certain information and the acceptance of other information.

For example, if the dispute involved a question of medical necessity, and the member submits a letter from his/her primary care physician indicating his/her option that the service requested is medically necessary in the special circumstances applicable to the member, the Grievance Committee cannot simply ignore the existence of such a letter. The record should clearly indicate the Committee's consideration of the PCP's opinion and its reasons for acceptance or rejection of the opinion.

We often find this failure to address physician input in cases related to cosmetic surgery. If the record contains letters from the member's PCP and a specialist indicating that in their professional opinion a procedure is not cosmetic, but medically necessary, the Grievance Committee cannot ignore such information. Again, if it chooses to reject these opinions and find the proposed surgery to be cosmetic and not medically necessary, the Grievance Committee must make a specific finding of why it rejected the opinions of the doctors supporting the member's position.

The Department also highly recommends that verbatim transcript of hearings be completed in cases of factual disputes. We have found that the summaries provided by many HMOs simply do not include enough of a record of the Grievance Committee's deliberations to demonstrate a full and fair consideration of the member's arguments in grievances containing factual disputes. In such grievances, the Department's review and decision would be expedited if it had a complete transcript containing a full record of the consumer's presentation to the Committee and the Committee's consideration of the consumer's presentation to the Committee and the Committee's consideration of the consumer's arguments and supporting documentation.

In addition, once the member leaves the hearing room, the Committee's discussion and deliberations regarding its reasons for making its decision should be "on the record" and contained in the transcript. Once again, this discussion should clearly reflect the member's supporting documentation and for accepting one party's versions of events as being more credible than another.

In summary, we highly recommend, but at this time will not require, that full transcripts be taken and submitted to the Department as part of the record in grievance hearings involving factual disputes. If the HMO decides not to take and submit a full transcript but to merely summarize the hearing, the Grievance Committee's decision must address each and every factual dispute and give full consideration of all evidence presented on behalf of the member's position.

IV. Issue #3 - Quality of Care Allegations

The Department has noted a tendency for HMO Grievance Committee records and decisions to ignore the quality of care allegations made by consumers within the context of grievance procedures. In some circumstances quality of care allegations arise within the context of a grievance to have a disputed claim paid. The quality of care dispute might be directly related to the grievance, e.g., the member alleges that he/she had to go to a non-participating provider because the PCP repeatedly misdiagnosed and mistreated his/her condition. Whenever any member makes an allegation about poor quality care, the Plan medical director is accountable for "closing the loop," including initiation of an appropriate investigation and incorporation of the results or findings of such an investigation into the packet of information which is made available to both the first and second level grievance committee. Such specific results and any corrective actions taken by the HMO may be considered confidential, and the details need not be disclosed to the member or included in the transcript; however, a conclusion of the results of the study needs to be in evidence as part of the proceedings. This is particularly important in cases where poor quality of care or inadequate medical management are alleged to have contributed to the substance of the member's grievance, or if it adds credibility to either the member's position or to the Plan's position.

The Plan clearly has the responsibility to investigate all allegations of poor quality care as a part of its quality improvement process. Certainly, the process of grievance resolution is one of the major sources of valuable information about potential problems with the quality or levels of care provided to members, and these should always be aggressively pursued and documented as a quality improvement initiative. This, minimally, would include documentation of an objective investigation by the medical director, including chart review, if appropriate, as well as the formulation of a quality improvement Plan or sanction if appropriate. All such investigations of poor quality care or poor medical management should also be routinely reported to the appropriate quality improvement committee so that trends can be identified and future problems avoided.

V. Issue #4 - Delegation of Grievance Handling

The Department of Health does not permit licensed HMO's to delegate responsibility for grievances to HMO subcontractors, e.g. managed are behavioral health subcontractors, physician-hospital organizations (PHOs) or special managed care Medical Assistance subcontractors. HMOs must be responsible for receiving and processing all grievances in accordance with DOH standards and members must have the right to appeal to the Department of Health if they are dissatisfied with the decision of the HMO's second level Grievance Review Committee.

For HMOs providing services to prepaid Medical Assistance enrollees, either directly or via a

subcontractor with a freestanding subcontractor specializing in Medical Assistance Managed Care, all grievances should be processed through the HMO's grievance system (and not through a grievance system established and maintained by a subcontractor.) Medical assistance HMO members appealing an HMO's decision to the Department of Health and dissatisfied with the Department of Health's decision, may then exercise their fair hearing right in accordance with the procedures of the Department of Public Welfare.