Appendix D: Analysis of Grievance Procedures - HMOs

Methodology

At the commencement of the study, all grievance procedures from HMOs licensed in the Commonwealth on file with the Bureau of Insurance were copied and sent to the Department of Health Evaluation Sciences at the University of Virginia. Researchers answered the questions contained in the analytical frameworks based on these documents. Interviews with the person or people deemed most responsible for these plans were arranged to go over the lists of questions for clarification. After three interviews with HMO representatives, it was determined that the documents received at DHES from the Bureau of Insurance were not the most current grievance procedures. In order to rectify this problem, the study methodology was changed slightly, allowing the HMOs to present their current plans. A tracking chart listing the HMOs and the status of their submissions follows the analysis of the grievance plans in this Appendix.

Based on several descriptive factors, a representative sample of HMOs licensed inVirginia was chosen for inclusion in the study. These factors included age of the plan, geographic region of service area, status of NCQA accreditation, number of total members and number of Virginia members, state of domicile, and tax-status. A total of seventeen (17) HMOs were chosen. In some cases, more than one plan from a particular company was chosen in order to make comparisons within companies. Contact information for each HMO was obtained from the Virginia HMO Association.

A research assistant initiated contact with the people deemed most responsible for grievance procedures at each plan. In some cases, the research assistant was referred to other employees of the plan. Once the correct person was reached, the research assistant explained the purpose of the study and outlined the requirements of participation. When consent was obtained, the research assistant faxed the lists of questions relating to grievance procedures. Each plan was instructed to complete the questions with relevant citations noted and to send current grievance procedures to DHES. They were requested to complete these tasks within 5 working days, and report back if they could not meet this deadline. Follow-up phone calls were utilized as reminders to those plans that did not respond within this time frame.

Questions for the study were provided by the Virginia Department of Health in consultation with the HB 2785 Study Group. All questions were sent to all potential participants in the study.

The following HMOs were contacted regarding their grievance procedures: Aetna, Cigna-MidAtlantic, Cigna-Virginia, HealthKeepers, HMO Virginia, John Deere, MD-IPA, NYLCare, Optima, Optimum Choice, Partners, Prudential-MidAtlantic, Prudential-Richmond (PruCare), QualChoice, Sentara, US Healthcare (now part of Aetna), and Virginia Chartered. Virginia Chartered was dropped from the study because no person able to respond to the questions could

be reached within the study time frame. Responses were received from John Deere, MD-IPA, NYLCare, Optimum Choice, HMO Virginia, HealthKeepers, Aetna/United Healthcare, QualChoice, Partners, Prudential-MidAtlantic, and Prudential-Richmond (PruCare).

Once the documentation and completed questionnaires were received at DHES, the researchers examined the answers and citations for completeness, accuracy, and clarity. Any questions were referred back to the individual plans. In addition, DHES interviewed appropriate personnel in order to supplement the information provided by the answers to the questions. Grievance procedures were compared to two national standards for utilization management: National Committee for Quality Assurance (NCQA) and the American Accreditation HealthCare Commission/URAC.

Analysis

Grievance Procedures

Twelve HMOs returned the completed questionnaire concerning their grievance procedures. One HMO did not return the completed questionnaire but did provide documentation of their procedures, so analysis was done on the information available. One company did not submit current grievance procedures, so answers could not be verified. The response rate, including the plan that only provided their grievance procedures, was 81%, and it can be reasonably assumed that these thirteen HMOs may be deemed a representative sample of all HMOs in the Commonwealth. Three companies, Aetna (which owns United Healthcare), Trigon (HMO Virginia and HealthKeepers) and MAMSI (MD-IPA and Optimum Choice), use the same grievance procedures for all their HMO products. Therefore, analysis was done on the grievance procedures submitted by each company rather than each plan, resulting in a total of nine sets of grievance procedures. Certain patterns in these grievance procedures emerged that merit consideration. Each question in the analytical framework has been answered using responses from the companies, followed by comments from the researchers. In some cases, the answers to the questions were not explicitly stated in the grievance procedures for each company. This has been noted where appropriate.

ANALYTICAL FRAMEWORK FOR EXAMINATION OF HMO GRIEVANCE PROCEDURES

1. How does the plan member know about the grievance procedure?

Six companies reported that grievance procedures were outlined in their member handbook. Three companies distributed this information in a publication entitled “The Evidence of Coverage,” which could be deemed a member handbook. Four companies presented information in more than one publication.

Comments: This information is very important and should be available to all members and providers in an easily understood format. This question did not address all the ways a member might receive this information, such as when a member calls with a complaint or question.

2. How many days does the plan member have after denial to ask for reconsideration?

The range for eight companies was from within 10 days to within a year, with three companies reporting 60 days. One of these companies noted that the time limit depends on the level of appeal. One company stated that they had no time limit restrictions.

Comments: This information was not explicitly stated in two of the companies' grievance procedures, but all plans gave this information to members in the member handbook. There is a concern that there might not always be enough time for the member to realize there is a problem. In the case of one company, a member only has ten days to request a reconsideration of a grievance and thirty days to file a formal complaint.

3. Who makes the first attempt to resolve the complaint?

One company encourages their members to contact their provider about medical treatment concerns before calling the plan itself. All companies have a member services or customer services department that handles calls directly from enrollees or provides an address to send written complaints. In one company, the type of complaint, written or oral, affects which department within the plan handles it. Another company stated that their goal is to have the complaint resolved informally.

Comments: It should be noted that "complaint" was viewed both as a regular complaint and as an appeal. This led to some confusion on the part of the respondents.

4. How many days does the HMO have to respond with a decision?

All companies have the policy of resolving complaints within 30 days of receipt. Response to appeals are usually shorter (within 10 days).

Comments: Again, some of the respondents did not know whether this question referred to a regular complaint or an appeal.

5. Do plan members have access to the names of members of the review panel?

One company does not allow members to have access to the review panel; there is a Grievance Coordinator who signs the letter of denial, which contains further appeal instructions. One company reported that members do not have access to the names of review panel members

except when the member requests to meet in-person with the whole panel. Five companies would allow access to the names of the review panel upon request from the plan member. One company explained that access to review panel members depended on the level and type of appeal or complaint; they stated that "consideration would be given" about disclosing names upon request of the member, but in certain cases (such as in the use of medical specialist consultants in reconsiderations), the names of the reviewers are not disclosed. One company chose not to respond to this question.

Comments: Review panels often change depending on the type of complaint (medical or administrative) and level of complaint. As seen in Question 23, the number and qualifications of the people on the panel changes significantly depending upon these factors.

6. Describe the first level of a formal appeal.

For all companies but one, formal appeals must be submitted in writing to the plan. Senior staff are involved in the appeals process at this stage. The decision may be made by an individual, such as the Medical Director (one company) or the Operations Manager (one company), or by an appeals committee (six companies). One company differentiates between a regular appeal and appeals that involve medical decisions; for the latter, all appeals must go through the Grievance Procedures.

7. How many days does the HMO have to respond?

This ranges between within 30 days and within 60 days.

Comments: The plans were assuming that this question referred specifically to response to a first level appeal. It should also be noted that neither NCQA nor URAC have exact standards about timeliness of response to appeals, except for the provision of expedited appeals. According to NCQA, by 1998 managed care organizations must meet specified industry standards for timeliness. Chapter 54 states that a person must be notified of the results of the appeal process no later than 60 working days after the HMO receives the required documentation.

8. Is there a second level appeal?

All companies that responded have second level appeals. This appeal must be in writing.

9. Does the plan member have a right to appear before the panel?

All plan members have the right to appear before a review panel if they request.

10. Is there a third level appeal?

One company allows their members to write a final letter of appeal to the President of the HMO. One company stated explicitly that a third level of appeal, arbitration, was available to plan members. One company mentioned the option of filing an appeal with a government agency such as the Bureau of Insurance, but noted that this was not a formal policy. The remaining companies answered no to this question.

Comments: All enrollees have the right to appeal to government agencies such as the Bureau of Insurance or HCFA, but most plans do not mention this in their member information.

11. Does the HMO have expedited appeal?

All companies have expedited appeals, but the time allowed for a decision ranges from 24 to 72 hours. One company referenced HB1973 of the Commonwealth of Virginia Statutes. One company urges the member to call them directly in case of emergency or urgent circumstances.

Comments: A process for expedited appeals is required by NCQA, URAC, and Virginia law. Both NCQA and URAC require that appeals be resolved within 72 hours.

12. Can the plan member complain orally?

All companies allow members to complain orally or in writing. Formal appeals must be in writing for eight of the nine companies.

Comments: There are again problems with definitions about what a complaint is. In one plan, oral complaints that can be handled over the phone are not recorded. In some plans, a complaint must be in writing for it to go through the appeals process. See Question 14.

13. Are there accommodations for non-English speakers and the handicapped?

Five companies mentioned specifically that they either contract with or have access to interpreters. Four companies reported that they made provisions for these populations, but were not specific. No companies had this information in their grievance procedures.

Comments: This information is often not contained in the member handbooks. “Access to interpreters” was not defined. Some members might have to wait for an interpreter to be contacted before their complaints or concerns can be conveyed to a plan.

14. What happens when a member calls with a complaint or concern?

All companies send these calls to the member services or customer services department. This information is available in all the grievance procedures, but the process in not always

explicitly stated. One company allows for verbal complaints as well as suggesting sending the complaint in writing to the plan. One company differentiates between informal complaints and concerns and complaints regarding a denial of benefits or services. The latter type must always be sent to the plan in writing, and callers are informed of this. Another company sends all complaints and concerns about providers received by phone directly to the quality improvement department, even if the complaint is resolved at the time of the initial call; other complaints are recorded verbally. Two companies state that resolution is attempted on the phone, and a complaint form is sent to the caller if he is not satisfied with the result. Two companies attempt to have their member services department handle all calls. One company allows members to file formal grievances over the phone; the customer services representative forwards the information to the grievance committee. One company did not elaborate.

Comments: The process of making a complaint is complicated and not always explained in easy terms to the plan member. Most of the member handbooks tell the enrollee to call the member services or customer services department with any concerns. It is up to the person receiving the call to help the caller progress through the system.

15. Is there a tracking system?

All companies reported that they utilize tracking systems for complaints and referenced them in their grievance procedures. Two companies only document complaints that cannot be resolved verbally on the phone. One company keeps a customer log for all phone inquiries and a complaint log for all written complaints. Five companies record all complaints, whether they are registered in writing or on the phone. One company did not elaborate about their tracking systems.

Comments: Again we saw a problem in the use of the term "complaint." The plan that differentiates between inquiries and complaints did not define those terms explicitly in their grievance procedures. This problem was consistent in all the plans. There is also some concern about the two companies that only record complaints that cannot be resolved on the phone; no effort is being made to track what these complaints entail.

16. Are complaints made through the Bureau of Insurance tracked separately?

Eight companies reported that these complaints are tracked separately. One company does not track them separately.

17. Is there anything unusual about the definition of a complaint?

One company reported that there was nothing unusual about the definition of a complaint, but a complaint was not defined specifically in their grievance procedures. One company states that there isn't anything unusual about the definition of a complaint. However, their grievance

procedures mention the differences between an inquiry or problem and a complaint. They do not give an explicit definition of any of these terms. One company did not give any definition of this term in its procedures or make a distinction between a complaint or any other type of grievance. Another company defined a complaint as "an oral or written expression of concern about the Plan or Plan providers." This definition was explicitly stated in their grievance procedures. One company defined a complaint as "a criticism or expression of dissatisfaction by a member," but this definition did not appear in their grievance procedures. One company made a distinction between a complaint (written or verbal expression of dissatisfaction) and a grievance (written expressions of dissatisfaction, usually a request for a decision reversal). These definitions did not appear in the grievance procedures or member handbook. Two other companies make a distinction between complaints (informal) and grievances (formal process). Finally, one company did report that a complaint differs from an appeal in that it is considered to be an expression of dissatisfaction regarding an administrative issue. Appeals are requests for reconsideration of an adverse decision.

Comments: Part of the problem with the answers to this question is with the ambiguity of the term "complaint." What we were trying to see was whether or not the HMOs differentiated between a complaint, an inquiry, and a formal grievance. It was determined through a reading of the companies' grievance procedures that definitions of these terms are not always clear.

18. If the HMO subcontracts with a managed mental health company, who handles complaints?

Three companies with subcontracted managed mental health services reported that members could utilize either the subcontractor's complaint procedures or the HMO's; complaints are registered with the primary HMO, regardless of where the initial complaint is made. Two companies handle all complaints, but one involves the subcontractor in clinical decisions and one has a special division dedicated to mental health concerns. All appeals for these companies must be made to the HMO, not the subcontractor. Two companies did not answer this question. Two companies do not subcontract for managed mental health services.

Comments: The complaint process is more complicated when an HMO subcontracts with another company to provide services. Members are encouraged to call the primary HMO, but they are not required to do so.

19. What is the basis for deciding medical necessity?

One company uses the definition of medical necessity as "services which are reasonably necessary in the exercise of good medical practice in accordance with professional standards accepted in the United States for the treatment of an illness or injury as determined by the Plans." This definition appears in the member handbook, but not explicitly in the grievance procedures.

Another company allows the Medical Director to make the determination of medical necessity based on certain criteria described in the grievance procedures. This company goes on to say that "The fact that a service is prescribed or recommended by a physician or other health care provider does not mean that the service is medically necessary or that it is a service covered under the Certificate." One company uses specific criteria from Milliman and Robertson and InterQual ISD/SIMs, but this information is not detailed in their grievance procedures. One company uses Milliman and Robertson and ISSI, and they also make use of internally developed protocols and guidelines. Another company mentions the use of medical record review and the application of nationally recognized criteria, but does not mention specific criteria. This company does state that if criteria are not met, the case is reviewed by a peer with similar training and background as the involved provider. One company did not define medical necessity, but it did mention that if an appeal is denied based on medical necessity, peer review would be conducted. One company stated that the HMO determines medical necessity, but does not elaborate on who makes these decisions. One company has the network provider determine medical necessity; if care is received out of network, the Medical Director and medical services department makes determinations. One company did not respond to this question.

Comments: The criteria for determining medical necessity should be explicit and shouldn't change no matter what the level of appeal is or who is actually determining medical necessity. Criteria are not described in detail in any of the companies' grievance procedures.

20. How are Medicaid grievances handled? Medicare? Federal Employees Health Benefit Plan (FEHBP)? Are grievance procedures different for these groups?

Three companies handle Medicaid enrollees; two companies use the same grievance procedures as with regular enrollees while one company utilizes the guidelines given by HCFA. For Medicare, four companies use the guidelines recommended by HCFA, two companies use the regular grievance process for informal and first level appeals but send second level appeals directly to HCFA, and three companies do not serve Medicare enrollees. For FEHBP, seven companies use the same grievance procedures as with regular enrollees with the stipulation that an enrollee can appeal to the Office of Personnel Management after a denial at the HMO level, one company uses specific FEHBP policies, and one company does not specify whether they handle enrollees in this type of plan.

Comments: Overall, grievance procedures are not significantly different for these groups (Medicaid, Medicare, FEHBP), but these enrollees are able to go to different agencies for higher level appeals. The information concerning Medicare was specifically mentioned in two companies' formal grievance procedures. These two companies did not reference the special appeals agencies available to Medicaid and FEHBP enrollees, but this information was available in their member handbooks.

21. Does the grievance procedure reference Chapter 54 of Title 38.2 of the Code of Virginia?

Are the procedures commensurate with Chapter 54?

No companies reference Chapter 54 specifically. Five companies reported that their procedures were commensurate with Chapter 54. One of these companies reported that "the average enrollee would not have ready access to the code."

Comments: Chapter 54 was passed in 1995 and its processes have not been used very often, which might explain why no specific references were found.

22. May a provider acting on behalf of an enrollee initiate a grievance?

Seven companies allowed for this process within their regular grievance procedures. One company had a special process for physician appeals. One company allows this only when the provider has written authorization from the member.

23. What are the positions and titles of the HMO review committee that decides grievances?

All companies mention the use of a review committee, but they differ on how much detail is given in their grievance procedures. One company uses a quality improvement task force as its complaint appeals panel; this panel includes the chief medical officer and several senior staff in the plan. Denial determination appeals make use of peer review members, and this information is stated in the grievance procedures. One company uses the Operations Manager in consultation with the Medical Director for first level appeals. At the second level, a Local Grievance Committee, made up of five members - none with medical degrees. Another company has an Appeals Committee consisting of the Medical Director, Medical Services Director, and the Customer Services Director. These individuals must not have been involved in prior decisions in the case, and at least one must be certified, licensed, or skilled in the same health care category as the provider involved in the dispute. These individuals can also appoint "similarly qualified designees." One company uses a committee made up of internal and external reviewers; currently four members of this panel have medical degrees. One company has a team of six, four of whom have medical degrees. One company uses a team consisting of a supervisor, a registered nurse, the Medical Director, and the Grievance Coordinator. One company has a Grievance Committee and an Appeals Committee, each with different membership; the Medical Director and the CEO sit on the Appeals committee. One company did not elaborate about the Local Appeal Committee used for level 1 appeals or the Operational Appeals Committee used for level 2 appeals, but the Medical Director is involved in both processes. One company chose not to answer this question.

Conclusions

The most striking finding from the above analysis is the lack of consistency in the definitions of many terms, including inquiries, complaints, and grievances. Our study questions

reflected this confusion and resulted in multiple and qualified answers to the same question. There are also many variants in the grievance process, ranging from informal oral processes to formal written processes. Information that is found in membership handbooks is often not found in the plan's official grievance procedures and vice versa. Official grievance procedures are not always given to plan members and providers, leading to confusion about where to start the process and how to navigate the process in general.

NAME OF HMO	*ORIGINAL QA PLAN*	*ORIGINAL GP PLAN*	*LATEST QA PLAN*	*LATEST GP PLAN*
* NYL CARE HEALTH	1996	No year provided	Selected/ Provided 1997	Selected/ Provided 1997
* OPTIMA	1994	1995	Selected/ Not Provided	Selected/ Not Provided
*MAMSI: OPTIMUM CHOICE	1990	1995	Selected/ Provided 1996	Selected/ Provided 1996
HUMANA GROUP	No date indicated	1992	Not Selected	Not Selected
* KAISER FOUNDATION MID.ATLANTIC	No QA provided	Revised in 1993	Not Selected	Not Selected
NATIONAL CAPITAL	No date indicated	No date indicated	Not Selected	Not Selected
* MD INDIVIDUAL PRACTICE	1994	1995	Selected/ Provided	Selected/ Provided
HERITAGE NATIONAL	1993	1993	Not Selected	Not Selected
* HMO VIRGINIA	No date indicated	1996	Selected/ Not Provided	Selected/ Not Provided
HEALTH FIRST & PRIORITY HEALTH	1994	No date indicated	Not Selected	Not Selected
* HEALTH KEEPERS	No date indicated	1996	Selected/ Not Provided	Selected Not Provided
HMO PLUS	No date indicated	1996	Not Selected	Not Selected
*QUAL CHOICE	No date indicated	1995	Selected/ Provided 1996	Selected/ Provided 1995
*PRUDENTIAL	1982	No date indicated	Selected Provided 1997	Selected Provided 1997
PRINCIPAL HEALTH CARE	Not date indicated	No date Indicated	Not Selected	Not Selected

NAME OF HMO	*ORIGINAL QA PLAN*	*ORIGINAL GP PLAN*	*LATEST QA PLAN*	*LATEST GP PLAN*
PHYSICIANS HEALTH PLAN	1983	No date indicated	Not Selected	Not Selected
PHN-HMO	1996	1996	Not Selected	Not Selected
PENINSULA HEALTH CARE	1996	None provided	Not Selected	Not Selected
* PARTNERS	1996	1996	Selected Provided 1997	Selected Provided 1997
* SENTARA	1994	1995	Selected Not Provided	Selected Not Provided
SOUTHERN HEALTH	1995	Revised 10/95	Not Selected	Not Selected
UNITED OPTICAL OF VA	No date indicated	None provided	Not Selected	Not Selected
US HEALTHCARE	1993	No date indicated	Selected Not Provided	Selected Not Provided
* VIRGINIA CHARTERED	No date indicated	No date indicated	Selected Not Provided	Selected Not Provided
* AETNA	1991	1996	Selected Not Provided	Selected Not Provided
CAPITAL AREA PERMANENTE	1981	None provided	Not Selected	Not Selected
CAPITAL CARE	No date indicated	1996	Not Selected	Not Selected
CHESAPEAKE	1995	No date indicated	Not Selected	Not Selected
CIGNA-MID-ATLANTIC	1994	1993	Not Selected	Not Selected
* CIGNA OF VA.	None provided	1995	Selected Not Provided	Selected Not Provided
COMM. PLANS, INC.	None provided	None provided	Not Selected	Not Selected
EQUICOR	No date indicated	None provided	Not Selected	Not Selected
GEORGE WASHINGTON UNIVERSITY	No date indicated	1995	Not Selected	Not Selected
* JOHN DEERE	1996	Not provided	Selected Provided 1996	Selected Provided 1996

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