

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE HMO APPEAL AND
GRIEVANCE PROCESSES**

Review of Cases



**JUNE GIBBS BROWN
Inspector General**

**DECEMBER 1996
OEI-07-94-00283**

OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

To determine the effectiveness of Health Maintenance Organizations' (HMOs) processing of Medicare beneficiary appeals and grievances through on-site reviews.

BACKGROUND

Beneficiaries may join a risk HMO through the Medicare program. For a predetermined monthly amount, the HMO provides Medicare covered medically necessary services. The goals of this coverage are to provide coordinated medical care, offer comprehensive benefits, and contain costs by using the most cost-efficient methods of treatment and preventing unnecessary care. As a protection for beneficiaries, the Social Security Act requires Medicare HMOs to have two separate and distinct processes, an appeal and a grievance process, to handle beneficiary complaints.

In order to protect beneficiaries from inappropriate denials of services or payment, the Act requires that Medicare HMOs establish an appeal process to handle these types of complaints. If an enrollee disagrees with the HMO decision to deny services or payment, the enrollee has 60 days to file a request for reconsideration. If the HMO's decision is against the beneficiary in whole or in part, the HMO is required to automatically send the case to the Network Design Group within 60 days for an independent Federal review.

All other complaints such as those relating to quality of care are processed under a separate internal grievance procedure. Under this procedure, there are no specific time frames or preordained levels of review established by law. However, HMOs are responsible for timely transmission, an investigation, decision, and notification of the results.

From a universe of 132 risk-based HMOs, we selected a purposive sample of 10 HMOs for on-site review. To provide a cross-section, HMOs were selected by number of enrollees, rate of appeals sent to Network Design Group, beginning contract date, location, and other criteria. Within the sampled HMOs, we randomly selected cases for review (144 appeals and 148 grievances) and analyzed them to determine whether procedural guidelines were followed, if complaints were being properly categorized, if time requirements were being met, and if problems or weaknesses existed in the appeal/grievance processes.

FINDINGS

Beneficiaries were not always advised of their appeal rights at the time services or payment were denied.

Regulations require HMOs to issue a written "initial determination" of denials and to advise patients of their right to request a reconsideration (appeal). Twenty-seven

percent of sample case files did not have initial determinations on file, 5 HMOs sent them without including the required appeals rights (6 cases), and 5 more sent the notice to beneficiaries after receiving their appeals (12 cases).

The HMOs did not properly distinguish appeals from grievances.

HMOs incorrectly processed appeal issues as grievances in 37 cases. This represents 26 percent of the 148 grievances we examined. Every plan made at least one such error. In addition, three incorrectly processed five complaints that included both appeal and grievance issues. The distinction between appeals and grievances is important to beneficiaries because appeal cases (denials of services or payment) are subject to independent Federal review for appropriateness of the HMO decision while grievances are only subject to internal HMO reviews.

The HMOs did not fully comply with Health Care Financing Administration (HCFA) directives for processing appeals and grievances.

Processing Appeals. Five HMOs did not refer eight denied cases to Network Design Group. Three did not document the basis for "good cause" for accepting 14 cases filed after 60 days. Five sent beneficiaries multiple initial determinations in nine cases. In addition, 5 HMOs had 13 cases where beneficiaries appealed several times before the plans would begin the appeals process.

Time Frames for Appeals. Five HMOs did not issue the initial determination within 60 days of the beneficiary's initial request for services or payment in 11 cases. One HMO waited two years before sending two cases to Network Design Group and resolution took five years. Nine plans did not make the reconsideration determination within 60 days or inform the beneficiary timely in 19 percent (28 cases) of our sample. Further, 4 HMOs did not send 9 cases to Network Design Group within the required 60 day time frame.

Resolving Grievances. One HMO suspends action on grievance cases while awaiting medical records. If records are not received, cases remain closed without resolution. One other plan had seven while another had two unresolved grievance cases that were either suspended without resolution or closed without resolution.

Documentation. Eight HMOs had undated initial determinations or did not have them on file in 46 appeals cases (32 percent of the sample). Five plans had 25 appeal cases (17 percent of the sample) where there were no dates on the reconsideration determinations or they did not have them on file. Five HMOs did not have documentation supporting that beneficiaries were notified of grievance results in 15 cases. Also, 6 had such poor documentation that it was impossible to reconstruct 16 appeal cases (11 percent) and 8 grievance cases (5 percent).

RECOMMENDATIONS

HCFA's Office of Managed Care is making substantial efforts to improve the HMO appeal and grievance processes. It has recently created a work group - Managed Care Appeals and Grievance Initiative - organized to make program improvements in these

functions. In 1995, HCFA's Office of Managed Care revised guidelines used by HCFA Regional Offices in their annual review of HMOs. In addition, HCFA in conjunction with Network Design Group, has conducted training sessions, provided technical assistance, and issued publications to improve HMOs' understanding and processing of appeals and grievances. HCFA plans to revise the HMO/CMP Manual and has received funds to evaluate problems in the area of appeals and grievances. However, as our findings reflect, there are areas where improvement is needed.

We recommend that HCFA

- ***ensure that HMOs correctly distinguish and process appeals and grievances.***

HCFA can accomplish this during their annual visits to HMOs. However, we suggest that HCFA conduct case reviews as well as examine the operating procedures to determine that appeals and grievances are processed correctly. We also suggest that HCFA focus closely on whether HMOs:

- are in compliance with all directives in processing of appeal and grievance cases;
 - include appeal rights in all initial determinations sent to beneficiaries; and
 - release initial determinations and reconsideration decisions in appeal cases according to established time frames.
- ***modify the HCFA HMO/CMP Manual to clarify and specify key requirements.***

This can be accomplished by:

- clarifying the explanation and language required on the appeal and grievance issues to improve HMOs' understanding of the differences and
 - establishing minimum requirements for documentation of appeal and grievance files so that an independent reviewer, based upon examining the files, will be able to follow and understand the adjudication by the HMO.
- ***broaden efforts to formally train HMOs on the appeal and grievance processes.***

We noted a significant amount of turnover in HMO staff responsible for processing appeals and grievance cases during this inspection. In light of this turnover, there is a need to continue training on a routine basis.

AGENCY COMMENTS

We solicited and received comments on our draft report from HCFA. They agreed with the conclusion of our reports that improvements are needed and indicated that they are working to implement a number of our recommendations. We are pleased

that HCFA agrees that improvements are needed in the appeal and grievance processes, and we recognize that changes are in the process of being made through the Medicare Appeals and Grievance Initiative (MAGI). However, because HCFA's response does not specifically address the recommendations contained in our reports, we are unsure whether the problems identified in our report will be fully addressed through this initiative. As a result, it will be important for HCFA to include in their response to the final report an action plan that specifically addresses each recommendation.

The full text of HCFA's comments is included as an appendix to this report.

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RELATED REPORTS

This is one of a series of four reports relating to Medicare risk HMO appeal and grievance processes. The four reports are:

Medicare HMO Appeal and Grievance Processes: Overview, (OEI-07-94-00280)

Medicare HMO Appeal and Grievance Processes: Beneficiaries' Understanding, (OEI-07-94-00281)

Medicare HMO Appeal and Grievance Processes: Survey of HMOs, (OEI-07-94-00282)

Medicare HMO Appeal and Grievance Processes: Review of Cases, (OEI-07-94-00283)

INTRODUCTION

PURPOSE

To determine the effectiveness of Health Maintenance Organizations' (HMOs) processing of Medicare beneficiary appeals and grievances through on-site reviews.

BACKGROUND

Legislation

Sections 1833 and 1876 of the Social Security Act specify the requirements that HMOs must meet in order to enter into a contract with the Health Care Financing Administration (HCFA) to furnish Medicare covered services to beneficiaries. The goals of HMO coverage are to provide access to medical care while containing costs by using the most cost-efficient methods of treatment and preventing unnecessary care. In addition, HMOs can reduce the medical management complexities experienced by elderly patients with multiple chronic conditions, the paperwork burden of a "fee for service" system, and financial barriers to obtaining preventive and medically necessary health care.

Unlike traditional "fee for service," HMOs are designed to coordinate care through a primary care provider, offer comprehensive benefits, and reduce or contain the costs of medical treatment. They operate under a fixed annual budget, based on the prepaid premiums. Except for fees of a few dollars for each doctor's visit or prescription, the premium is to cover all of a patient's medical needs which include everything from checkups to open-heart surgery.

Risk and Cost Plans

There are three types of Medicare HMO plans included in the Act. Generally, the differences involve the method used by HCFA to reimburse the HMO for providing services and delivering medical services to beneficiaries. The three types of contracts are risk-based, cost-based, and Health Care Prepayment Plan (or HCPP) HMOs. The latter two types are paid on a reasonable cost basis, wherein any differences in actual costs and interim payments are reconciled and adjusted with HCFA at the end of the year. Risk-based are reimbursed on a prepaid capitation basis with no retrospective adjustment. While cost-based and HCPP HMOs give beneficiaries a choice of physicians that they see, a risk-based plan requires enrollees to be "locked" into only its contracted physicians unless emergency or urgent care is needed.

As of March 1, 1996, there were 197 risk-based HMO plans, 27 cost-based plans, and 54 HCPPs nationwide, which accounted for almost 4 million Medicare HMO enrollees, or 10 percent of the total Medicare population. While Medicare enrollment in managed care has increased 67 percent since 1993, HCFA reports that enrollment in risk-based plans has grown 105 percent.

Appeal & Grievance Processes

One of the most effective ways HMOs contain costs is by using family practitioners or internists as "gatekeepers" to control a patient's access to services. The patient chooses one doctor as a primary care physician; from then on that doctor serves as first arbiter for any treatment. The primary care physician provides medical examinations and treatments, and serves as a "gatekeeper" to specialty care, except in emergency and urgent care situations.

Because the payment mechanism of HMOs provides a strong incentive to manage utilization of enrollee medical services (including the institution of a physician "gatekeeper" and use of medical practice guidelines), the Act requires that HMOs establish an appeal process to handle disputes Medicare enrollees have involving a denial of or payment for services they believe should be covered by the HMO. Other kinds of complaints such as quality of care received are handled under a grievance procedure. Prior to May 1995, only risk and cost-based plans were required to have these processes in place. HCPPs now must also comply with these requirements.

HCFA directives require HMOs to inform beneficiaries of their appeal/grievance rights at enrollment, in member handbooks, and annually through a newsletter or other communication.

Appeals process - According to 42 CFR, Sections 417.600-638, an appeal is any dispute involving a denial of services or payment for services made by the HMO. Federal regulations and the HMO/CMP¹ Manual require a five-step process and time limits for each step. HMOs must make an initial determination upon receiving an enrollee's request for services or payment for services within established time frames (24 days if the case is complete and no later than 60 days if development is needed). Each plan is required to make a decision on information they currently have within this time frame. If the decision is to deny services or payment, the enrollee has 60 days from the date of the initial determination to file a request for reconsideration (appeal) in writing unless "good cause" can be shown by the beneficiary for the delay. The HMO then has 60 days to make a reconsideration decision.

If the HMO's reconsideration decision is against the beneficiary in whole or in part, the HMO is required to automatically forward the case to HCFA for an independent review to determine if the decision is appropriate. Due to the increasing numbers of appeal cases, HCFA contracted with Network Design Group (NDG) in January of 1989 to fulfill this function. The number of appeals reviewed by NDG has varied in the last 3 years from a high in 1993 of 3,806, to 2,945 in 1994, and 3,691 in 1995.

Beneficiaries whose cases are not resolved fully in their favor at the NDG level can request a hearing before an Administrative Law Judge (ALJ) if the disputed amount is at least \$100. After this level, any party (including the HMO) may request a review by the Department of Appeals Board if there is dissatisfaction with the ALJ's decision or

¹ Competitive Medical Plan

dismissal. The final recourse in the appeals process is a Federal court review if the Board denies the party's request for review, and the amount in controversy is \$1,000 or more.

Grievance process - Grievances are any complaints about a Medicare enrollee's experience with the health plan and/or its providers, excluding determinations involving payment for services or denial of services (which are subject to the appeals process). Examples of grievable issues include quality of care, physician behavior, involuntary disenrollment concerns, and waiting times for services.

Guidance for processing grievances is found in 42 CFR, Sections 417.600 and 417.606, and in Section 2411 of the HMO/CMP Manual. The guidelines do not provide for time frames or specify levels of review, but call for "timely" transmission, an investigation, decision, and notification of the results. While appeal cases that are not resolved fully in favor of the beneficiaries are subject to independent HCFA, ALJ, Appeals Board, and Federal court review, beneficiary grievances are only subject to internal levels of review within the HMO.

The Office of Managed Care (OMC) within HCFA is responsible for policy and oversight of HMOs and ensuring there is compliance with the appeal and grievance regulations. To assist plans in these processes, OMC has created the appeal and grievance sections in the HMO/CMP Manual.

METHODOLOGY

From a universe of 132 risk-based HMOs obtained from HCFA's April 1995 "Monthly Report of Medicare Prepaid Health Plans," we selected a purposive sample of 10 HMOs for on-site review. We did not include cost-based plans and HCPPs in the sample as the majority of Medicare beneficiaries are enrolled in risk-based HMOs. We based our selection upon the number of enrollees, rate of appeals sent to NDG (including no appeals and highest rates of appeals), number of appeals overturned at this level, beginning contract date, and percent of retroactive disenrollment². Also, an important factor in our selection was location; two plans were selected in close proximity to each other for economy of travel and for geographical representation within the country.

While we randomly selected 150 appeal cases and 150 grievance cases (15 of each in the plans), the HMOs were able to provide only 144 appeals and 148 grievances for

² Retroactive Disenrollment is an administrative procedure established by HCFA to reverse a beneficiary's enrollment back to Medicare fee-for-service participation. An example where this might be used is in a case where HCFA determined that a beneficiary did not understand how HMOs operate at the time of enrollment and incurred large out-of-pocket expenses from services obtained outside the HMO. In this case, HCFA may approve a retroactive disenrollment which would require an HMO to reimburse premiums paid by the beneficiary and the medical bills would be processed through Medicare.

our review. One HMO had only 8 appeal cases in our sample time frame (1/1/94 to 7/31/95), and at another we sampled 16 cases. Because the latter plan was unable to provide us a universe of cases, we selected on-site eight cases from 1994, and eight cases from 1995. In the grievance sample, one HMO had only 13 cases in the universe. We analyzed the cases to determine whether procedural guidelines were followed, if appeals and grievances were being properly categorized, and if time requirements were being met. We also reviewed cases to determine if there were problems or weaknesses in the appeal/grievance processes.

Because we used a purposive sample of HMOs, the results from this study only apply to them and cannot be projected to the universe of Medicare risk HMOs.

We conducted our review in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

BENEFICIARIES WERE NOT ALWAYS ADVISED OF THEIR APPEAL RIGHTS AT THE TIME SERVICES OR PAYMENT WERE DENIED

According to 42 CFR 417.608, HMOs are required to send a written "initial determination" of any negative decision to beneficiaries within 60 days of their request for services or payment for services. The notice must advise beneficiaries of their right to appeal these decisions. Our case reviews revealed that some HMOs in our sample did not comply with these requirements. See Appendix A for detailed information on the numbers of cases where HMOs were not fully in compliance with HCFA directives.

Twenty-seven percent of our sample case files did not have initial determinations on file.

In our appeal sample of 144, 8 HMOs did not have initial determinations in 27 percent or 39 case files. There was no evidence that beneficiaries were sent the initial determinations or given their appeal rights. One of these HMOs did not have initial determinations in 10 out of 15 case files and could not produce them upon request.

This finding is supported by our companion report "Medicare HMO Appeal and Grievance Processes: Beneficiaries' Understanding" (OEI-94-07-00281). In that inspection, we found that 41 respondents (9.6 percent) considered they were denied services. Of these 41, 34 (83 percent) beneficiaries reported that they did not receive the required notice explaining the denial and appeal rights. Similarly, a total of 39 respondents (8 percent) were denied payment. Of these, 9 (23 percent) reported they did not receive this required notice.

Five HMOs sent initial determinations without including appeals rights.

These five plans sent denial notices to beneficiaries in six cases without including instructions on their right to appeal the decision. The notices sent to beneficiaries contained only the reason for the denial. We also noted that an HMO sent 2 additional initial determinations in 1 case, including appeal rights, but gave beneficiaries less than the required 60 days to file a request for reconsideration. The beneficiary was given two business days to appeal in one notice and seven days to respond to the second notice.

HMOs sent initial determinations to beneficiaries AFTER receiving the request for reconsideration.

Five HMOs sent initial determinations after receiving the beneficiary's request for reconsideration in 12 cases. One of these plans sent an initial determination on the same day the case was sent to NDG. In four other cases, it sent the letter from four to seven months after receiving the request for reconsideration.

THE HMOs DID NOT PROPERLY DISTINGUISH APPEALS FROM GRIEVANCES

HMOs incorrectly processed cases with appeal issues as grievances.

The 42 CFR 417.606 requires that HMOs completely separate disputes involving appeal issues (i.e., denials of or payment for services) and grievance issues (i.e., quality of care or waiting time for services). They are required to process beneficiary disputes under one process or the other, depending on the nature of the case. While appeal cases are subject to independent Federal review and various other levels of appeal, grievances are resolved internally, without the same protection of independent reviews.

In our review we identified 37 cases (26 percent) where appeal requests were improperly processed as grievances. Examples include:

- One HMO processes cases with appealable issues as either an appeal or a grievance based on whether the HMO provides an initial determination in writing to the beneficiary. If the case involves an appealable issue and the HMO does not issue a written initial determination, the case is incorrectly processed as a grievance. There were three such cases incorrectly processed in our sample.
- Another HMO had 7 cases with appealable issues in its grievance sample of 13 that were incorrectly processed as grievances, more than half of its sample cases. This HMO also had five cases in the appeal sample that were initially processed as grievances.
- Two other HMOs indicated during interviews that they had incorrect processes, however, no cases were found in the 30 reviewed in their sample. One HMO indicated that they attempt to resolve cases containing both an appeal and a grievance through their "informal" grievance process. If the beneficiary is dissatisfied with the decision, the plan attempts to process the case through their "formal" grievance process. The other HMO indicated that "When a doctor refuses care, it is treated as a grievance - informal, or formal if in writing. The grievance would go to either the Peer Review or NDG." This HMO is treating an appealable issue as a grievance.

As a result of incorrectly processing appeals as grievances, beneficiaries may be denied full due process. These beneficiaries may not receive their right to an independent Federal review and may suffer financial expenses and potential harm to their health.

Some HMOs incorrectly processed complaints that included both appeal and grievance issues.

The HCFA HMO/CMP Manual Section 2400.1 instructs HMOs to process separately and simultaneously those cases with both appeals and grievances. Issues in these cases are not to be resolved through one process and then the other if the beneficiary is

dissatisfied with the results. However, three plans in our sample did not comply with these guidelines in five cases.

One HMO in our sample incorrectly processed a case that involved both an appealable (\$16,200) and grievable issue through the grievance process. After processing the case as a grievance and resolving the grievance issue, it eventually processed the appeal, sending the initial determination to the beneficiary seven months after the request for reconsideration, and then to NDG one month after this. NDG overturned the HMO decision and the claim was paid almost 12 months after the beneficiary first filed the appeal.

THE HMOs DID NOT FULLY COMPLY WITH HCFA DIRECTIVES FOR PROCESSING APPEALS AND GRIEVANCES

Processing Appeals

Referral of Appeal Cases to NDG. While the HMO/CMP Manual Section 2405.3 requires all denials, whether partial or full denial cases, be forwarded to NDG within 60 days of request, we found some HMOs did not forward cases and sent beneficiaries multiple reconsideration determinations.

- Five HMOs in our sample did not forward eight denied or partially denied cases (six percent) to NDG. These cases were closed without resolution and the beneficiaries were not provided the right to an independent Federal review.

In one appeal case, it was explained to the beneficiary that the service would not be covered and the case was closed without giving the beneficiary full due process. The case was not sent to NDG for review as required.

- One HMO sent multiple negative reconsideration determinations in response to a non-plan provider's requests for payment in two cases over a span of two years. The non-plan provider wrote numerous letters to this HMO requesting they forward the cases to NDG and twice furnished copies of HCFA's instructions of how to forward cases to NDG prior to it complying.

Good Cause. According to the HMO/CMP Manual Section 2405.1(C), HMOs accept requests for reconsideration filed after the 60 day deadline if beneficiaries reveal circumstances that show "good cause" for the delay. Examples include: the beneficiary did not receive the initial determination, was seriously ill, or had an accident that destroyed important records. To accept these late requests for reconsideration, HMOs must establish the reason for the beneficiary's delay in filing an appeal.

Three HMOs did not document the basis for "good cause" when accepting appeals filed after 60 days in 14 cases, or 10 percent of the sample. One HMO had eight cases, or over half of its sample appeal cases where they were accepted without

requiring the beneficiary to show "good cause." One appeal case was accepted two years after the initial determination was sent.

Delays in Processing Appeals. HMO/CMP Manual Section 2405.4(A) states that HMOs should "never issue more than one denial notice for a request for service or item or payment for an out-of-plan claim." When a beneficiary files a request for reconsideration, the HMO has already denied the case once and should automatically send it to NDG within 60 days if the decision is upheld. In our sample, we found examples of appeal cases that were processed incorrectly.

- Five HMOs sent beneficiaries multiple initial determinations in nine cases (six percent) in our sample. One plan sent six initial determinations in one case, while another plan sent three in one case.
- Five HMOs had 13 cases (9 percent) where beneficiaries had to request a reconsideration determination multiple times before the HMO began the appeals process.

Time Frames for Appeals

Although 98 percent of the 132 HMOs surveyed in our companion inspection ("Medicare HMO Appeal and Grievance Processes: Survey of HMOs" [OEI-94-07-00282]) reported in their responses that appeals are processed within the required time frame, case reviews revealed that some HMOs did not meet these requirements.

- The 42 CFR 417.608 requires the initial determination be sent within 60 days of request for payment or services. Failure to issue a written notice within this time frame constitutes an adverse initial determination which the beneficiary may appeal. Five HMOs in our sample did not issue the initial determination within the 60 days of the request in 11 cases.
- The HMO/CMP Manual Section 2403.1 requires that HMOs process claims within 24 days if complete and no later than 60 days if development is needed. However, one plan had two cases in our sample that had not been paid since 1990. The provider was appealing for payment two years after services were rendered. These 2 case files contained 1992 documentation showing the non-plan provider had 13 additional appeals pending with this HMO since 1990. Resolution of the two sample cases took five years.
- HMOs are to make the reconsideration determination within 60 days from the time the appeal is filed. However, 9 plans did not make the reconsideration determination within this time frame or inform the beneficiary timely in 19 percent (28 cases) of the our sample. The case file reviews showed that HMOs made the determinations from 3 to 11 months past the due date. We noted that 1 made its determinations late in 7 out of 15 cases.

- One HMO in our sample has a pre-service denial procedure that causes inordinate delays in processing appeals. A contracted plan physician requests HMO authorization for a referral with the plan denying the referral until proof of medical necessity is provided. This cycle may occur several times before a beneficiary questions the delay or files an appeal. These beneficiaries may not receive due process if the HMO does not send the initial determination even though the referral has been denied multiple times. Our review revealed 3 cases where the HMO, after multiple internal denials were made, sent the initial determination 4 to 5 months past the required 60 days.
- The HMO/CMP Manual Section 2405.3(A) requires that HMOs automatically send reconsiderations to NDG within 60 days of the request if denied in part or in full. They are required to meet this time frame even if the file is incomplete or pending medical records. In our reviews, however, we found four HMOs that did not send nine cases to NDG within this time frame.
- The HMO/CMP Manual Section 2405.4(B) instructs HMOs to notify NDG within 60 days that decisions on overturned cases have been carried out. Our file review reflects that four plans in our sample did not notify NDG of payment in seven overturned cases within the time requirements.

Resolving Grievances

- The 42 CFR 417.600 and 417.606 requires HMOs to investigate and resolve grievance cases in a timely manner. We found one plan that suspends action on grievance cases while awaiting receipt of medical records. Cases remain closed and are re-opened only if the medical records are received. As a result of this incorrect process, cases are not being resolved. In our sample, we found two cases which had been closed pending medical records in this HMO.
- While required to resolve grievance cases, one HMO in our sample had seven unresolved grievances and another had two cases that were either left open or closed without resolution.

Documentation

- Eight HMOs had undated or undocumented initial determinations on file in 46 (32 percent) of the sample cases. Half of these plans had 7 to 12 cases with insufficient information. Not having these vital documents dated or on file causes difficulty in assessing timeliness and poses a problem for HMOs in proving they sent beneficiaries, with appeal disputes, the required initial determination and appeal rights.
- Five HMOs had 25 cases (17 percent) with undated or undocumented reconsideration determinations on file. Without the date on the

reconsideration determination, it is extremely difficult to determine if the HMO made this decision within the 60 day requirement.

- HMOs are required to inform the beneficiary of their decision within 60 days from the time the appeal request was filed. Although there are minimal directives for processing grievance cases, regulations also mandate that HMOs notify beneficiaries of the results of grievance disputes. However, we found 4 HMOs in our sample that had 20 appeal cases (14 percent) and 5 HMOs with 15 grievance cases where there was no evidence that the beneficiary was ever notified of results.
- Six HMOs had such poor documentation that it was impossible to reconstruct 16 appeal cases (11 percent) and 8 grievance cases (5 percent). HMOs refer to notices, attachments, beneficiary letters, and phone calls but did not keep them on file. One plan had completely separate files documenting this information in two different departments. However, this important information was not reconciled or reviewed with the appeal or grievance files. Another HMO rarely documented its modes of communication with the beneficiary and retained little documentation on cases.

RECOMMENDATIONS

HCFA's Office of Managed Care is making substantial efforts to improve the HMO appeal and grievance processes. It has recently created a work group - Managed Care Appeals and Grievance Initiative - organized to make program improvements in these functions. In 1995, HCFA's Office of Managed Care revised guidelines used by HCFA Regional Offices in their annual review of HMOs. In addition, HCFA in conjunction with Network Design Group, has conducted training sessions, provided technical assistance, and issued publications to improve HMOs' understanding and processing of appeals and grievances. HCFA plans to revise the HMO/CMP Manual and has received funds to evaluate problems in the area of appeals and grievances. However, as our findings reflect, there are areas where improvement is needed.

We recommend that HCFA

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HCFA can accomplish this during their annual visits to HMOs. However, we suggest that HCFA conduct case reviews as well as examine the operating procedures to determine that appeals and grievances are processed correctly. We also suggest that HCFA focus closely on whether HMOs:

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- include appeal rights in all initial determinations sent to beneficiaries; and
- release initial determinations and reconsideration decisions in appeal cases according to established time frames.

- ***modify the HCFA HMO/CMP Manual to clarify and specify key requirements.***

This can be accomplished by:

- clarifying the explanation and language required on the appeal and grievance issues to improve HMOs' understanding of the differences and
- establishing minimum requirements for documentation of appeal and grievance files so that an independent reviewer, based upon examining the files, will be able to follow and understand the adjudication by the HMO.

- ***broaden efforts to formally train HMOs on the appeal and grievance processes.***

We noted a significant amount of turnover in HMO staff responsible for processing appeals and grievance cases during this inspection. In light of this turnover, there is a need to continue training on a routine basis.

AGENCY COMMENTS

We solicited and received comments on our draft report from HCFA. The complete text of their response is included as an appendix to this report. A summary of their comments and our response follows.

The HCFA agreed with the conclusion of our reports that improvements are needed and indicated that they are working to implement a number of our recommendations. We are pleased that HCFA agrees that improvements are needed in the appeal and grievance processes, and we recognize that changes are in the process of being made through the Medicare Appeals and Grievance Initiative (MAGI). However, because HCFA's response does not specifically address the recommendations contained in our reports, we are unsure whether the problems identified in our report will be fully addressed through this initiative. As a result, it will be important for HCFA to include in their response to the final report an action plan that specifically addresses each recommendation.

Although HCFA acknowledges the case review report identifies mistakes made by health plans, they expressed concerns about the sample sizes and number of cases reviewed. We agree that this sample could not be used to make national projections of the incidence of mistakes. However, the number of cases reviewed and outcomes of the reviews are more than adequate to indicate the existence of significant problems in HMO processing of appeals and grievances.

Finally, HCFA raised questions about the knowledge and expertise of the individuals who prepared the HMOs' responses to our survey documents. We requested and must assume that knowledgeable HMO staff completed our survey. We also note that beneficiaries making inquiries regarding appeals and grievances are likely to be interacting with these same individuals or their staff.

APPENDIX A

Problem Areas Detected In On-Site Review Of HMO Case Files

| ON-SITE REVIEW OF APPEAL/GRIEVANCE CASE FILES ¹ AND ERRORS | | | | | | | | | | |
|---|----------------------------|---|----|---|-----------------|---|---|---|---|---|
| AREAS IN ERROR | 10 HMOs BY NUMBER OF CASES | | | | | | | | | |
| | A | B | C | D | E | F | G | H | I | J |
| BENEFICIARIES WERE NOT ALWAYS ADVISED OF THEIR APPEAL RIGHTS AT THE TIME SERVICES OR PAYMENT WERE DENIED | | | | | | | | | | |
| HMOs did not have evidence of giving beneficiaries appeal rights in initial determination. (27% or 39 cases) | - | - | 10 | 6 | 2 | 2 | 6 | 4 | 8 | 1 |
| HMOs sent initial determinations without appeal rights included. (4% or 6 cases) | 1 | - | - | 1 | 2 | - | - | 1 | - | 1 |
| HMOs sent initial determinations AFTER receiving the request for reconsideration. (8% or 12 cases) | 6 | - | - | - | 2 | 1 | 2 | - | - | 1 |
| THE HMOs DID NOT PROPERLY DISTINGUISH APPEALS FROM GRIEVANCES | | | | | | | | | | |
| HMOs incorrectly processed cases with appeal issues as grievances. (26% or 37 cases) | 3 | 1 | 1 | 3 | 12 ² | 5 | 3 | 5 | 1 | 3 |
| HMOs incorrectly processed cases with both appeal and grievance issues. (3% or 5 cases) | 2 | - | - | - | - | 1 | - | 2 | - | - |
| HMOs DID NOT FULLY COMPLY WITH HCFA DIRECTIVES FOR PROCESSING APPEALS AND GRIEVANCES | | | | | | | | | | |
| Processing Appeals | | | | | | | | | | |
| HMOs did not forward partially or fully denied cases to NDG. (6% or 8 cases) | 1 | - | 3 | - | 1 | - | - | 1 | 2 | - |
| HMOs sent multiple reconsideration determinations in cases denying payment over two years prior to forwarding cases to NDG. (1% or 2 cases) | - | - | - | - | 2 | - | - | - | - | - |
| HMOs did not show "good cause" for accepting beneficiary cases filed past the 60 day requirement. (10% or 14 cases) | - | - | - | - | 3 | - | 8 | 3 | - | - |

| ON-SITE REVIEW OF APPEAL/GRIEVANCE CASE FILES ¹ AND ERRORS | | | | | | | | | | |
|--|----------------------------|---|---|---|---|---|---|---|---|---|
| AREAS IN ERROR | 10 HMOs BY NUMBER OF CASES | | | | | | | | | |
| | A | B | C | D | E | F | G | H | I | J |
| HMOs sent beneficiaries more than one initial determination. (6% or 9 cases) | 2 | - | - | 1 | 2 | 2 | - | - | 2 | - |
| HMOs did not begin the appeals process until beneficiaries requested a reconsideration multiple times. (9% or 13 cases) | 5 | - | - | 1 | 2 | 2 | 3 | - | - | - |
| Time Frames for Appeals | | | | | | | | | | |
| HMOs did not make the initial determination within the 60 day requirement. (8% or 11 cases) | 6 | - | - | - | 2 | 1 | - | 1 | - | 1 |
| HMOs did not pay claims timely within 60 days of request (cases were not paid until 5 years after service). (1% or 2 cases) | - | - | - | - | 2 | - | - | - | - | - |
| HMOs did not make reconsideration determination within 60 days of beneficiary request. (19% or 28 cases) | 4 | 2 | 6 | 1 | 7 | 1 | 1 | 5 | - | 1 |
| HMO's pre-service denials caused inordinate delays in the process. (2% or 3 cases) | 3 | - | - | - | - | - | - | - | - | - |
| HMOs did not forward cases to NDG within the 60 days required. (6% or 9 cases) | 1 | - | 3 | - | 3 | - | - | 2 | - | - |
| HMOs did not notify NDG when decisions on overturned cases were carried out. (5% or 7 cases) | 1 | - | - | - | 2 | - | 1 | 3 | - | - |
| Resolving Grievances | | | | | | | | | | |
| HMOs suspend unresolved grievances while awaiting receipt of medical records. Cases remained closed unless the HMO received the records. (1% or 2 cases) | - | - | - | - | - | - | 2 | - | - | - |
| HMOs did not resolve grievance cases; cases were left open or closed without resolution. (6% or 9 cases) | 2 | - | - | - | - | - | - | - | - | 7 |

| ON-SITE REVIEW OF APPEAL/GRIEVANCE CASE FILES ¹ AND ERRORS | | | | | | | | | | |
|--|----------------------------|---|-----|----|-----|-----|-----|----|------|-----|
| AREAS IN ERROR | 10 HMOs BY NUMBER OF CASES | | | | | | | | | |
| | A | B | C | D | E | F | G | H | I | J |
| Documentation | | | | | | | | | | |
| HMOs either did not have dates on initial determinations or evidence of sending them to beneficiaries. (32% or 46 cases) | - | - | 12 | 9 | 3 | 2 | 7 | 4 | 8 | 1 |
| HMOs either did not have dates on reconsideration determinations or did not have them on file. (17% or 25 cases) | 1 | - | 6 | 1 | - | - | - | 6 | 11 | - |
| HMOs did not have evidence of notifying beneficiaries of the results of the HMO reconsideration determinations. (14% or 20 cases) | - | - | 3 | 1 | - | - | - | 7 | 9 | - |
| HMOs had no evidence of notifying beneficiaries of the results from grievances cases. (10% or 15 cases) | 3 | - | 1 | - | 2 | - | - | - | 3 | 6 |
| HMOs had such poor documentation that it was impossible to recreate appeal (a) and grievance (g) cases. (appeals - 11% or 16 cases, grievances - 5% or 8 cases) | - | - | 5 a | - | 3 g | 1 a | 1 g | - | 10 a | 4 g |
| Total Number of Errors in Cases by HMO | 41 | 3 | 50 | 24 | 52 | 18 | 34 | 44 | 54 | 26 |
| ¹ Review was based on 144 appeal cases and 148 grievance cases within 10 HMOs. ² HMO had 7 cases with appeal issues in the grievance sample that were processed as grievances and 5 cases in the appeal sample that were processed initially through the grievance process for a total of 12 cases. | | | | | | | | | | |

APPENDIX B

Health Care Financing Administration Response to Report



DEC 12 1996

DATE:

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Reports: "Medicare HMO Appeal and Grievance Processes--Overview," (OEI-07-94-00280); "Medicare HMO Appeal and Grievance Processes--Beneficiaries' Understanding," (OEI-07-94-00281); "Medicare HMO Appeal and Grievance Processes--Survey of HMOs," (OEI-07-94-00282); "Medicare HMO Appeal and Grievance Processes--Review of Cases," (OEI-07-94-00283)

We reviewed the above-referenced reports that examine the operations of the Medicare risk-based HMOs appeal and grievance processes. We agree with the conclusion of your report that improvements are needed and are working to implement a number of your recommendations. Our detailed comments are attached.

Thank you for the opportunity to review and comment on this report.

Attachment

**Health Care Financing Administration (HCFA) Comments
on Office of Inspector General (OIG)**

Draft Reports: "Medicare Health Maintenance Organizations' (HMO) Appeal and Grievance Processes: "Overview," (OEI-07-94-00280); Medicare HMO Appeal and Grievance Processes: "Beneficiaries' Understanding," (OEI-07-94-00281); "Medicare HMO Appeal and Grievance Processes: "Survey of HMOs," (OEI-07-94-00282); "Medicare HMO Appeal and Grievance Processes: "Review of Cases," (OEI-07-94-00283)

OIG Recommendations

OIG recommends that HCFA take the following actions to address problems highlighted in the above studies:

- o Actively monitor HMOs to ensure beneficiaries are issued written determinations.
- o Work with HMOs to establish standardized appeal and grievance language requirements in marketing/enrollment materials and operating procedures.
- o Ensure that HMOs correctly distinguish and process appeals and grievances.
- o Require HMOs to report Medicare contract-specific data on appeal and grievance cases.
- o Modify the HMO/CMP Manual to clarify and specify key requirements.
- o Broaden efforts to formally train HMOs on the appeal and grievance processes.

HCFA Response

We agree that improvements are needed. We have a comprehensive effort underway called the Medicare Appeals and Grievance Initiative (MAGI) which includes a number of objectives that are directly related to the recommendations in your reports. Our objectives include identifying and meeting the information needs of beneficiaries regarding their appeal rights; promoting health plan accountability by developing and improving information on appeals and making meaningful information more available; and refining mechanisms for monitoring and assisting in the continuous improvement of health plan performance.

OIG and HCFA jointly issued a Medicare beneficiary advisory bulletin entitled, "What Medicare Beneficiaries Need to Know About HMO Arrangements: Know Your Rights." This easy-to-read document contains information on appeal rights, filing complaints, and rights to emergency and urgently needed services. Copies of this bulletin are being distributed nationally. Additionally, significant changes were made to improve the managed care portions of the Medicare Handbook, which was sent to all beneficiaries this year. New data reporting requirements on plan-level reconsiderations are under development and may be instituted as early as mid-1997. We also plan to restructure and shorten the time lines for handling health care decisions and reconsiderations by health plans.

Beneficiaries' Understanding

We are pleased to see the high level of knowledge among Medicare enrollees regarding their right to appeal and file complaints. This is an improvement over an earlier finding, and one we believe results from both Federal program and plan efforts at educating beneficiaries and providing notices. With regard to the finding that beneficiaries had a lesser level of awareness as to when to exercise their appeal rights, forthcoming regulations clarifying the right to appeal when services are reduced or terminated, and when to provide notices of noncoverage at these points in care management, should significantly help address this problem. We will consider the recommendations in this area.

Survey HMOs

Incorrect categorization of appeals as grievances is an area for improvement identified in our MAGI initiative. However, we question the percentage and methodology set forth in this report. Because certain staff within the organizational structure of an HMO, or staff at delegated medical groups within the HMO's network, are generally responsible for assigning complaints to the appeals or grievance track, it would be important to know who responded to the two questions asked on this subject and what role they play in this particular process. We will be moving to identify the source problems, such as staff turnover and confusion over differences in Federal and state terminology.

The type of statistical information sought by OIG staff has not been a requirement for Medicare-contracting health plans. Therefore, it is not surprising that many plans aggregate the appeals information across commercial, Medicare, and Medicaid members. New plan-level appeals reporting requirements should resolve the need for Medicare-only information, and respond to your recommendation.

Review of Cases

We have concerns about the small sample sizes and number of cases used to present findings in this report. However, the report identifies the types of mistakes health plans make in operating an appeals system, and the needs that plans have for clear, distinct information and training about the Medicare managed care requirements (and how these differ from state requirements for their commercial and Medicaid enrollees). We will consider the recommendations presented.