Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE HMO APPEAL AND GRIEVANCE PROCESSES

Survey of HMOs

JUNE GIBBS BROWN
Inspector General

DECEMBER 1996
OEI-07-94-00282

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EXECUTIVE SUMMARY

PURPOSE

To evaluate the effectiveness of Health Maintenance Organizations' (HMOs) processing of Medicare beneficiary appeals and grievances.

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.

To determine how HMOs were implementing these processes, we surveyed 132 Medicare risk-based HMOs that had at least 450 enrollees in April 1995. We also obtained and analyzed marketing/enrollment materials and operating procedures from these HMOs.

FINDINGS

HMOs incorrectly categorized appeal and grievance issues.

Fifty percent of the HMOs responding to our survey categorized appealable issues as grievances, while 36 percent categorized grievance issues as appeals, and 10 percent reported using incorrect processes for cases involving both appealable and grievable 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.

HMOs' marketing/enrollment materials and operating procedures that we reviewed contain incorrect or incomplete information on appeal and grievance rights.

Sixty-six percent of the HMOs distribute materials to beneficiaries and 69 percent of HMOs use operating procedures that contain either incorrect or incomplete information regarding beneficiary appeal and grievance rights. Some examples include no information on beneficiary rights, incorrectly combined appeal and grievance processes, and inaccurate definitions or no distinction between appeals and grievances.

HMOs do not maintain statistical information needed for the ongoing evaluation of appeal and grievance practices.

Twenty-three HMOs (18 percent) could not produce the statistical information requested for this inspection relating to numbers of appeal and grievance cases. This poses significant problems considering that such statistical information is needed by the Health Care Financing Administration (HCFA), beneficiaries, and others as a basis for evaluating HMO performance.

Some HMO staff report they do not have a HCFA HMO/CMP[1] Manual - others report need for improvements in the Manual.

Eight HMOs (six percent) report that staff responsible for processing appeals and grievances do not have the HMO/CMP Manual, the manual created by Office of Managed Care for HMOs to use as guidelines in these processes. Others report a need for improvement in the guidelines for appeals and grievances (10 percent), additional services (23 percent), and emergency/urgent care (7 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. Currently, they are also working with HMOs to develop national guidelines for marketing materials, improve informational publications, research data reporting needs, and have obtained funds to evaluate problems in the area of appeals and grievances. While HCFA's efforts should favorably impact these processes, we believe there is still room for improvement.

[1] Competitive Medical Plan

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.

- ***work with HMOs to establish standardized appeal and grievance language requirements in marketing/enrollment materials and operating procedures.***

  - In marketing materials, provide up front information to beneficiaries on their rights under the appeal and grievance processes and

  - In enrollment materials, more thoroughly educate beneficiaries about their specific rights under the appeal and grievance processes, including

    --a detailed overview of the types of services, lack of services, or situations which may be appealed or grieved.

    --when and under what circumstances further levels of appeal are permitted.

    --clarification that only appeals and not grievances, are subject to independent Federal review.

    --the difference between the definitions of emergency and urgent care at the time medical services are being sought.

- ***require HMOs to report Medicare contract specific data on appeal and grievance cases.*** At a minimum, include:

  - number of appeal and grievance cases (including formal and informal grievances);
  - number of cases resolved internally and externally, and outcomes of cases;
  - issues involved in cases; and
  - time it takes to resolve the cases (upper and lower limits, median/mean).

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.

TABLE OF CONTENTS

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 evaluate the effectiveness of Health Maintenance Organizations' (HMOs) processing of Medicare beneficiary appeals and grievances.

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/CMP 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 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

In this inspection, we surveyed and collected procedures and marketing/enrollment materials from 132 risk-based HMOs, each with at least 450 Medicare enrollees as of April 1995. The survey instrument was tested in three HMOs to ensure understandability and comprehension. Our universe of HMOs came from HCFA's "Monthly Report of Medicare Prepaid Health Plans." We did not include cost-based and HCPPs in the sample as the majority of Medicare beneficiaries are enrolled in risk-based HMOs. We received survey responses from all 132 risk-based HMOs and compiled this data into frequency distributions. We also conducted a content analysis of all materials received from the HMOs comparing them to Federal regulations and the HMO/CMP Manual, and whether they provide a reasonable approach for processing beneficiaries' complaints.

This report is based on our review of self-reported information and materials received from the HMOs.

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

FINDINGS

HMOs INCORRECTLY CATEGORIZED APPEAL AND GRIEVANCE ISSUES

- ***Fifty percent of the HMOs categorized appealable issues as grievances.***

The incorrect processing of denials of services or payment for services as grievable issues has important implications. Because grievable issues are only subject to HMOs' internal review, beneficiaries are being denied due process as established by 42 CFR 417.622 for appeal cases, and the right to an independent Federal review of an HMO's negative determination. Further, beneficiaries may suffer out-of-pocket expenses and potential health related problems from inappropriate denials.

To determine how HMOs categorize complaints, we asked the plans in two separate survey questions to identify from a list of options which complaints are considered appealable and which are grievable. The number of errors in categorizing appeal and grievance issues is shown in Table 1. The table illustrates the amount of confusion HMOs had in categorizing the issues. In completing their surveys, some HMOs responded that certain issues were considered as both appeals and grievances.

Table 1

HMOs[1] INCORRECTLY CATEGORIZING APPEALS & GRIEVANCES

Appealable Issues	HMOs did not consider these issues as Appealable[2]	HMOs considered these issues as Grievable[3]
Emergency versus urgent care	18 (14%)	33 (25%)
Non-admission to hospital	15 (11%)	26 (20%)
Non-referral to specialist	10 (8%)	21 (16%)
Denial of service	1 (.1%)	20 (15%)
Denial of payment for services	0 (0%)	14 (11%)
Grievable Issues	**HMOs considered these issues as Appealable**	**HMOs did not consider these issues as Grievable**
Dissatisfaction with medical care received	11 (8%)	7 (5%)
Beneficiary complaints not taken seriously	6 (5%)	10 (8%)
Physician demeanor towards beneficiary	6 (5%)	5 (4%)
Waiting times for services	5 (4%)	6 (5%)

[1] Some HMOs considered the issue as both an appeal and grievance.
[2] Fifty percent or 66 HMOs were in error in one or more area when asked which issues they consider appealable.
[3] Thirty-six percent or 47 HMOs were in error in one or more area when asked which issues they consider grievable.

A further analysis of the responses is provided in Appendix A (page A-1) which presents information on the *most common* grievance issues reported by HMOs. As noted at the bottom of the Appendix, some HMOs reported that their most common issues received and resolved through the grievance process were actually appealable issues.

- ***Thirty-six percent of the HMOs categorized grievance issues as appeals.***

  Although grievable issues can involve serious allegations of quality of care or mistreatment of beneficiaries, current regulations only require HMOs to process them internally. They are not subject to an independent, Federal review. Nevertheless, treating grievance cases as appeals adds unnecessary costs, HMO staff time to prepare, and can consume NDG's time if the case reaches that level (NDG is responsible only for processing beneficiary appeal cases). Refer to Table 1 for details illustrating HMO's confusion in categorizing appeal and grievance issues.

  For further details on this issue, see the lower portion of Appendix A (page A-2). One HMO reported the *most common* issue received and resolved through the appeals process was actually a grievable issue.

- ***Some HMOs incorrectly process cases with both appealable and grievable issues.***

  The HMO/CMP Manual Section 2400.1 requires that HMOs process complaints that contain both appeal and grievance issues separately and simultaneously rather than through one process or the other. In our survey, thirteen (10 percent) of 132 plans reported they do not process these issues separately and simultaneously. Three of these plans indicated they handle both appeal and grievance issues through the grievance process.

HMOs' MARKETING/ENROLLMENT MATERIALS AND OPERATING PROCEDURES THAT WE REVIEWED CONTAIN INCORRECT OR INCOMPLETE INFORMATION ON APPEAL AND GRIEVANCE RIGHTS

The HMO/CMP Manual Section 2402 requires HMOs to inform all enrollees of the appeal and grievance procedures and to provide a written description at the time of enrollment as part of the membership materials. It requires them to clearly distinguish between appeal and grievance issues in all written explanations. For appeals, HMOs are to describe all steps of the process, from the initial determination by the health plan to the judicial review rights after exhausting administrative appeal rights. It is to include time limits, amount in controversy requirements, and procedures for filing appeals. The grievance process explanation must include how to file, time limits for filing, and time limits for each step in the process.

As part of this inspection, we requested that HMOs send us their marketing and enrollment materials distributed to Medicare beneficiaries. Our analysis was specifically based on materials received from HMOs.

We found that 66 percent of the HMOs distribute materials to beneficiaries that contain either incorrect or incomplete information on their appeal/grievance rights in HMOs. Further, we found that 69 percent of HMOs use operating procedures for processing appeals and grievances that are deficient. Examples are HMOs that have

- no information on beneficiary rights.
- inaccurate definitions of appeal and grievance issues, unclear distinctions between them, or no information included.
- inaccurate definitions of emergency and urgent care, unclear distinctions between them, or no information related to these issues.
- incorrect or no money amounts included within the steps of the appeal process.
- incorrect procedures that combine appeals and grievances processes.
- incomplete explanation of the grievance process.
- erroneous extra steps and time added to the appeals process.
- inaccurate or incomplete time frames included in explanations of steps in the appeals process.

Appendix B identifies the frequency in which we noted errors by category. These errors could impact the level of understanding beneficiaries have of these processes. Incomplete or incorrect information in materials distributed to them may cause confusion. Further, inaccurate operating procedures may result in HMOs incorrectly processing appeals and grievances.

HMOs DO NOT MAINTAIN STATISTICAL INFORMATION NEEDED FOR THE ONGOING EVALUATION OF APPEAL AND GRIEVANCE PRACTICES

Twenty-three HMOs could not produce the statistical information related to appeals and grievances.

Although all HMOs reported that they retain statistics on appeals and grievances, and review data for trends and processing times, Table 2 reveals that almost one-fifth of the HMOs were not able to produce statistical information on appeals and grievances.

These figures are potentially understated; they do not include those HMOs where incomplete statistical information was submitted with the survey nor those that responded with "N/A" when the plan meant it does not retain data in the areas we requested.

TABLE 2

HMOs COULD NOT PROVIDE STATISTICAL INFORMATION

Reasons for Lack of Information	Number of HMOs
Could not separate statistical information by contract on appeals and grievances when the HMO had multiple Medicare risk contracts.	14 (11%)
Could not separate Medicare from commercial enrollees to provide information on appeals and grievances.	3 (2%)
Could not produce data for a specified time because they either did not retain it during the time requested or never had retained this information.	3 (2%)
Could not separate appeal cases from grievance cases in the database.	2 (1.5%)
Could not include all grievance cases filed by enrollees when the HMO processed "formal" and "informal" grievances separately.	1 (1%)
Total Number of HMOs	**23 (17.5%)**

HMOs reported the following main reasons for being unable to provide this information:

- they do not retain data separately when an HMO has multiple Medicare contracts and all appeals and grievances were processed at headquarters;
- they retain combined data of commercial and Medicare complaints; and
- they do not have the staff or computer systems to collect or retain the data.

This results in difficulty in data collection and analysis of the data. The information HMOs do report may be skewed or unreliable as not all HMOs retain the same data, if it is retained at all. For example, one large HMO in our sample initially reported it had 345 grievances. However, upon further investigation, it actually had over 37,000 grievances. The problem was that the HMO initially reported only the grievances that they considered as "formal" and not the "informal" grievances. Thus, it appeared the HMO had very few grievances when in fact it had thousands.

Lack of consistent terminology for complaints, and the collection, retention, and reporting of data makes it extremely difficult to truly compare HMOs. This is highly problematic given that such statistical information is needed by HCFA, beneficiaries, and others as a basis for evaluating HMO performance.

While HMOs are not currently required to report this information to HCFA, OMC officials and a number of reports cite the importance and appropriateness of collecting, retaining, and reporting data.[2]

SOME HMO STAFF REPORT THEY DO NOT HAVE A HCFA HMO/CMP MANUAL - OTHERS REPORT NEED FOR IMPROVEMENTS IN THE MANUAL

Eight HMOs (six percent) report that staff responsible for processing appeals and grievances do not have the HMO/CMP Manual. This is problematic considering that the Manual serves as a major guidance directive for HMOs in preparing local guidelines and for training staff. Of these HMOs, three improperly categorized appeal and grievance issues.

While most plans report this Manual is sufficient, others report areas that they believe need improvement.

General Guidelines

Thirteen HMOs (10 percent) report that guidelines for appeal and grievance issues in the HMO/CMP Manual are unclear and inadequate. Of these HMOs, six improperly categorized appeal and grievance issues.

HMOs also indicated the need for simplified definitions of appeals and grievances and examples of each. They stated that providing information in "lay" terms on these processes would be helpful in explaining them to beneficiaries. HMOs indicated that appeal and grievance terminology established by HCFA for HMO materials is difficult for beneficiaries to understand.

Additional Services

Thirty-one HMOs (23 percent) reported that guidelines on "additional services" relating to appeal rights are inadequate and unclear. Of these HMOs, 14 improperly categorized appeal and grievance issues.

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[2] HCFA's OMC has incorporated this issue in their "Managed Care Appeals & Grievance Initiative," a workgroup designed to improve these processes; General Accounting Office (GAO), "Medicare: Federal Efforts to Enhance Patient Quality of Care (April 1996), 29; GAO, "Medicare: Increased HMO Oversight Could Improve Quality and Access to Care" (August 1995), 10-11; Public Citizen's Health Research Group, "Serious problems for Older Americans In Health Maintenance Organizations" (May 1995), 10; The Columbia Law Review 1994,"Notes: Securing Access To Care in Health Maintenance Organizations: Towards a Uniform Model of Grievance and Appeal Procedures" (June 1994), 22.

An "additional service" is one that is covered under the HMO's plan but is not covered under traditional fee-for-service Medicare. For example, denial of payment or authorization for a hearing aid that the beneficiary believes is needed, which is covered in the basic plan, is appealable. However, optional supplemental benefits elected by the beneficiary and paid for through additional premium payments are grievance issues.

Most HMOs reported that this issue is confusing and unclear. Very little is included in the HMO/CMP Manual and the regulations on "additional services" and appeal rights. The plans indicated that clearer demarcation between what is appealable and grievable and examples of each would be helpful.

Emergency and Urgent Care

Nine HMOs (seven percent) reported that the difference between emergency care and urgent care, as defined by HCFA guidelines, is problematic.

HMOs believe that the definition of "urgent care" is very broad and requires the plans to cover an extremely wide range of out-of-area services. Several plans indicate that it would be helpful for both HMOs and beneficiaries if HCFA would provide working examples of each.

Although emergency and urgent care are defined in both the regulations and the HMO/CMP Manual, emergency room services was the second highest appeals issue in cases sent to NDG in 1993 and 1994. In NDG's 1994 data report, 595 (19 percent) of the appeals received involved emergency services disputes. Of these cases, NDG upheld 68 percent and, on average, these cases involved out-of-pocket liability of $579. This could be a result of beneficiary confusion about the difference between emergency and urgent care.

Our companion report "Medicare HMO Appeal and Grievance Processes: Beneficiaries' Understanding" also provides detailed information on beneficiary comprehension of billing disputes involving emergency services. In our survey, only 20 percent of the disenrollees and 59 percent of enrollees knew they could appeal their HMO's refusal to pay a doctor or hospital for emergency care for which they were billed.

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. Currently, they are also working with HMOs to develop national guidelines for marketing materials, improve informational publications, research data reporting needs, and have obtained funds to evaluate problems in the area of appeals and grievances. While HCFA's efforts should favorably impact these processes, we believe there is still room for improvement.

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.

- ***work with HMOs to establish standardized appeal and grievance language requirements in marketing/enrollment materials and operating procedures.***

  - In marketing materials, provide up front information to beneficiaries on their rights under the appeal and grievance processes and

  - In enrollment materials, more thoroughly educate beneficiaries about their specific rights under the appeal and grievance processes, including

    --a detailed overview of the types of services, lack of services, or situations which may be appealed or grieved.

    --when and under what circumstances further levels of appeal are permitted.

    --clarification that only appeals and not grievances, are subject to independent Federal review.

    --the difference between the definitions of emergency and urgent care at the time medical services are being sought.

- ***require HMOs to report Medicare contract specific data on appeal and grievance cases.*** At a minimum, include:

  - number of appeal and grievance cases (including formal and informal grievances);
  - number of cases resolved internally and externally, and outcomes of cases;
  - issues involved in cases; and
  - time it takes to resolve the cases (upper and lower limits, median/mean).

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

HMO SURVEY - Report on Process Operations

MOST COMMON GRIEVABLE ISSUES REPORTED BY HMOs

Grievable Issues	Number of HMO Responses[1]
Quality of care	57
Waiting time for services	19
No trends, not enough grievances received yet	16
Physician demeanor	8
Optional benefit issues	7
Dissatisfaction with services or provider services	7
Referral guidelines	2
No response from HMO	2
Premium rates	1
Physician preference in medical office	1
Billing cycle	1
Enrollment status	1
Being placed on hold too long on telephone	1
Co-pay disputes	1
Disputes where no further liability exists for beneficiary	1
Podiatry disputes	1
Customer service	1
Issues that should have been listed as appeal issues[2]	
Denial of payment for services	5
Denial of services	3
Emergency/urgent care	2
Total Responses	137

[1] HMOs responded with multiple issues resulting in 137 total.

[2] HMOs reported the most common issues received and resolved through the grievance process actually were appealable issues. These HMOs are incorrect in processing these issues as grievances.

MOST COMMON APPEALABLE ISSUES REPORTED BY HMOs

Appealable Issues	Number of HMO Responses[1]
Denial of payment for services	93
Denial of services	17
Emergency/Urgent care	12
Non-referral to specialist	6
No trends, not enough appeals received yet	5
Exceeding plan benefits	2
Podiatry coverage	1
Issue that should have been listed as a grievance issue[2]	
Emergency Room Copay	1
Total Responses	137

[1] HMOs responded with multiple issues resulting in 137 responses.

[2] The HMO reported the most common issue received and resolved through the appeal process actually was a grievable issue. This HMO is incorrect in processing the issue as an appeal.

APPENDIX B

PROCEDURAL AND MARKETING/ENROLLMENT INFORMATION REPORTED BY THE HMOs[1]

Area in Error	Procedures[2]	Marketing/ Enrollment[3]
Definition		
HMO does not clearly distinguish between appeals and grievances.	10	14
HMO incorrectly categorizes appeal and grievance issues.	14	3
HMO includes no information on either appeal or grievance processes.	-	37
HMO incorrectly defines emergent care.	4	6
HMO incorrectly defines urgent care.	21	9
HMO does not clearly distinguish between emergent and urgent care.	1	9
No information was included on emergent and urgent care.	1	2
HMO does not mention money amounts for appeals steps or has incorrect amounts.	11	8
Processing		
HMO has incorrect procedures that combine appeals and grievances processes.	9	4
HMO does not include all steps of the appeals process.	N/A[4]	20
HMO does not explain the complete grievance process (i.e., what is grievable, process, time limits, etc.).	11	16
HMO does not consider telephone complaints as grievances until they receive the complaint in writing.	1	-
HMO does not accept appeals without a written initial determination.	1	-
HMO adds steps and time to the appeal process - not in compliance with Regulations.	6	2
HMO does not notify beneficiary that the appeal is favorable if the decision is made within 15 days of filing.	1	-
HMO will not give a reconsideration determination unless case is $100 or more.	1	1

Area in Error	Procedures[2]	Marketing/ Enrollment[3]
Processing		
HMO incorrectly treats appealable issues as grievances; if "a grievance concerning denial of a claim or a bill for services where the amount in controversy exceeds $100 may be appealed to HCFA." If $1000 or more, the member is entitled to judicial review of HCFA decision. (This HMO does have a completely separate process for appeals).	-	1
Time Requirements		
HMO includes no time frames in appeal processes.	8	2
HMO does not mention they will make the initial determination within 60 days of receipt of request.	15	9
HMO did not explain that beneficiaries have to file within 60 days of initial determination.	18	3
HMO does not mention they will make reconsideration within 60 days of the request.	28	15
HMO does not include "if favorable, HMO will pay within 60 days" as required.	45	11

[1] Total number of errors is beyond 132 HMOs - many HMOs had multiple errors in the materials.
[2] Sixty-nine percent or 91 HMOs had either incorrect or incomplete information in their operating procedures for processing appeals and grievances.
[3] Sixty-six percent or 87 HMOs had either incorrect or incomplete information in their marketing/enrollment materials for processing appeals and grievances.
[4] HMOs were asked to provide the HMO procedures for processing appeals, not all steps in the appeal process.

APPENDIX C

Health Care Financing Administration
Response to Report

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

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:

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