

## BEHAVIORAL HEALTH ISSUE BRIEF SERIES

### Designing a Complaint and Grievance System and Other Member Assistance Services Under Medicaid Managed Care<sup>1</sup>

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February, 2000

### Introduction

Medicaid beneficiaries enrolled in managed care arrangements have two basic sets of procedural protections when benefits are denied. The first set consists of the right to timely and adequate notice of “any action affecting [a] claim”<sup>2</sup> for medical assistance, as well as a fair hearing in the case of any individual “whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.”<sup>3</sup> The second is the right to “internal grievance” procedures to “challenge the denial of coverage \*\*\* or payment [of medical] assistance.”<sup>4</sup> The Health Care Financing Administration (HCFA) is expected to delineate the specific elements of each of these procedural safeguards in a managed care environment -- as well as how the two sets of protections relate to each other -- in forthcoming regulations implementing the Balanced Budget Act (BBA) of 1997.<sup>5</sup>

This Issue Brief examines how state Medicaid agencies approach the issue of grievances and appeals in their contracts with managed care organizations (MCOs) furnishing comprehensive services. The source of information for this Issue Brief is the MCO contract data base maintained by the Center for Health Services Research and Policy and supported

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<sup>1</sup> The Department of Health and Human Services has reviewed and approved policy-related information within this document, but has not verified the accuracy of data or analysis presented. The opinions expressed herein are the views of the authors and do not necessarily reflect the official position of the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Care Financing Administration (HCFA), or the U.S. Department of Health and Human Services.

<sup>2</sup> 42 C.F.R. §431.206(c)(2).

<sup>3</sup> Section 1902(a)(2) of the Social Security Act; 42 U.S.C. §1396a(a)(3). Regulations implementing the fair hearing requirements of the law are found at 42 C.F.R. §431.201-250. In 1970 the United States Supreme Court established timely and adequate notice and fair hearings as constitutionally protected rights in the case of welfare benefits in *Goldberg v Kelly*, 397 U.S. 254 (1970).

<sup>4</sup> Section 1932 (b)(4) of the Social Security Act; 42 U.S.C. §1396u-2(b)(4).

<sup>5</sup> Proposed rules were issued at 63 Fed. Reg. 52022 on September 29, 1998.

in part by the Substance Abuse and Mental Health Services Administration.<sup>6</sup> As a result, this Issue Brief focuses on grievance and appeals procedures for enrollees of managed care organizations and does not address the procedural protections available to individuals who are enrolled in other forms of managed care, such as primary care case management systems.<sup>7</sup>

The Issue Brief begins with a general discussion of the managed care grievance process and then examines the grievance provisions of managed care contracts.

## Part 1. Overview

Managed care merges health care coverage and health care treatment. As coverage and treatment have become synonymous, the existence, design, and operation of a process for fairly and expeditiously resolving member complaints and grievances regarding treatment has become a staple of managed care quality measurement and improvement.

The managed care industry recognizes the importance of a system for resolving disputes regarding access to care. Grievance procedures are now classified as a component of managed care operations for accreditation purposes.<sup>8</sup> In recent months at least one national managed care organization has voluntarily adopted an external appeals process for members who challenge certain types of treatment decisions.<sup>9</sup>

Both the Medicare and Medicaid programs require managed care organizations to provide grievance systems for enrollees.<sup>10</sup> In addition, Medicare enrollees are entitled to an external review of internal grievance decisions,<sup>11</sup> and as of the end of 1998, 13 states had similar external review systems in place for commercial enrollees.<sup>12</sup> The Advisory Commission on Consumer Protection and Quality in the Health Care Industry (hereinafter referred to as the Quality Commission) also has recommended the establishment of internal grievance and external appeals procedures for all privately insured Americans.<sup>13</sup> Legislation

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<sup>6</sup> See Sara Rosenbaum et al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts* (3<sup>rd</sup> Ed.) (The George Washington University Medical Center, School of Public Health and Health Services, Washington, DC (1999)).

<sup>7</sup> The final BBA regulations are expected to address procedural protections for all forms of managed care.

<sup>8</sup> See, e.g., National Committee for Quality Assurance, *Accreditation 1999* (Washington, DC (1999)).

<sup>9</sup> Aetna U.S. Health Care announcement, June, 1999.

<sup>10</sup> 42 C.F.R. §§422.560-422.590 (Medicare+Choice, i.e., the managed care component of the Medicare program); 42 C.F.R. §434.32 and proposed regulations at 63 Fed. Reg. 52086-89 (September 29, 1998) (Medicaid).

<sup>11</sup> 42 C.F.R. §405.801 et seq.

<sup>12</sup> Depending on how state external review statutes are drafted and Medicaid managed care systems are regulated, these private external review procedures may or may not apply to Medicaid enrollees. For example, in a state that codifies its external review system as part of its state insurance laws but simultaneously exempts Medicaid managed care products from state laws regulating insurance, the external review process might be inapplicable.

<sup>13</sup> In 1998 a federal court ruled that state laws covering grievances and external review were laws that “related to” employee benefit plans and were not “saved” as laws that regulate insurance under the Employee Retirement Income Security Act (ERISA). As a result, it would appear that where they exist, state laws regulating grievance and appeals procedures for managed care enrollees do not apply to members of employee benefit plans covered by ERISA. For a general discussion of ERISA and its effects on external review systems,

enacted in 1999 by both Houses of Congress and awaiting a final conference agreement would establish grievance and appeals systems for insured Americans.<sup>14</sup>

Federal Medicaid regulations governing state contracts with health maintenance organizations and other MCOs provide that a contract must contain an internal grievance procedure that is “approved in writing by the agency”, provides for “prompt resolution” of disputes, and assures “the participation of individuals with the authority to require corrective action.”<sup>15</sup> These regulations will be augmented by HCFA’s Quality Improvement System for Managed Care (QISMC), which provides guidance to states regarding the nature and structure of grievance systems.<sup>16</sup> Statutory amendments enacted in 1997 effectively codify this pre-existing regulation by requiring state agencies that mandate managed care arrangements as a state plan option to ensure that the MCOs with which they contract have an “internal grievance procedure” under which members can challenge the denial of coverage or payment.<sup>17</sup>

The Medicaid MCO grievance system offers a means for resolution of disputes regarding general concerns about managed care, as well as claims against companies regarding the correctness of their medical treatment decisions. Policy makers have concluded that it is possible to design an internal grievance system to work reasonably fairly and more rapidly than other forms of review, despite the conflict of interest between an MCO’s initial decision-making and review roles. Because the grievance system may be the fastest and easiest remedy available to members, QISMC encourages its use not only for general concerns, but also as a means of resolving treatment disputes.<sup>18</sup>

## **Part 2. Key Elements of a Managed Care Organization Grievance Process**

Over the past several years, as interest in plan grievance systems has grown, numerous policymakers, including the Quality Commission, Congress, HCFA (through QISMC), and the courts, have identified a number of factors that arise in considering the fairness and adequacy of an internal grievance system, the steps that must be taken to make a system workable, and the steps to be taken to minimize the potential for conflicts of interest.

*The Quality Commission.* In its 1997 Consumer Bill of Rights and Responsibilities, the Quality Commission identified certain minimum elements for internal grievance systems:

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see Rand Rosenblatt, Sylvia Law, and Sara Rosenbaum, *Law and the American Health Care System* (Foundation Press, New York, NY (1997 and 1999-2000 Supplement)).

<sup>14</sup> S. 1344; H.R. 2990. The measures contain important differences with respect to the structure and breadth of their grievance provisions. Phyllis Borzi and Sara Rosenbaum, *Pending Patient Protection Legislation: A Comparative Analysis of Key Provisions of the House and Senate Versions of H.R. 2990* (prepared for the Henry J. Kaiser Family Foundation, December, 1999).

<sup>15</sup> 42 C.F.R. §434.42.

<sup>16</sup> See also HCFA’s Dear State Medicaid Director Letter dated February 20, 1998, dealing with changes regarding grievance procedures for eligible Medicaid enrollees, at <http://www.hcfa.gov/medicaid/bba2208d.htm>.

<sup>17</sup> Section 1932(b)(4) of the Social Security Act; 42 U.S.C. §1396u-2(b)(4).

<sup>18</sup> See QISMC at §2.4.

- Timely, written notification of a decision to deny, reduce, or terminate services or deny payment for services. Such notification should include an explanation of the reasons for the decisions and the procedures available for appealing them.
- Resolution of all appeals in a timely manner, with expedited consideration of decisions involving emergency or urgent care consistent with time frames required by Medicare (e.g., 72 hours).
- A claim review process conducted by health care professionals who are appropriately credentialed with respect to the treatment decision involved. Reviews should be conducted by individuals who were not involved in the initial decision.
- Written notification of the final determination by the plan of an internal appeal that includes information on the reason for the determination and how a consumer can appeal that decision to an external entity.
- Reasonable processes for resolving consumer complaints about such issues as waiting times, operating hours, the demeanor of personnel, and the adequacy of facilities.

*Congress.* In the Congressional debate regarding managed care quality, several bills have expanded on these basic recommendations and identified additional aspects of an internal grievance system. The most important of these is the requirement that the grievance and appeals system should cover *any* treatment decision that involves *medical judgment* (i.e., any judgment regarding coverage that necessitates an evaluation of medical facts), not merely those coverage decisions that involve a question of *medical necessity*. This issue is one of great importance because increasingly contracts of coverage are being drafted with an emphasis on broad exclusionary terms in an attempt to minimize cases in which the decision can be characterized as an individual determination of medical necessity.<sup>19</sup>

The importance of this distinction can be seen in the following example: A managed care contract excludes coverage for cosmetic surgery. The managed care company denies coverage for surgery on a child's cleft palate, classifying it as "cosmetic." The basis of the denial is *not* that the service is not medically necessary; instead, the service is denied on the ground that it is "cosmetic" and therefore excluded. To reach this decision, however, the company's medical reviewers had to consider the child's medical condition and whether in the child's case the treatment was medical in nature or merely cosmetic.

*QISMC.* The Quality Improvement System for Managed Care recognizes two basic categories of issues that members may raise with their MCOs: issues related to the actual provision of services, and all other issues, which can be classified as more generalized complaints.<sup>20</sup> QISMC recommends the following elements for a grievance system:

- written intake procedures for enrollee requests that allow the MCO to determine if the request involves a coverage-related grievance or a more generalized complaint;
- notification of the member regarding which process will be used and assistance with completion of the process, and notification regarding available external review procedures, if any;

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<sup>19</sup> *Law and the American Health Care System* op. cit., Ch. 2(E).

<sup>20</sup> See QISMC at §2.4.

- the submission of grievances to knowledgeable persons who have the authority to take action;
- notice regarding the proposed resolution and an opportunity for the member to seek reconsideration of the proposed solution;
- a mechanism for tracking grievances to the point of resolution;
- an expedited system for grievances requiring immediate resolution;
- adherence to applicable timelines;
- review of grievances involving questions of medical necessity by qualified physicians; and
- maintenance of records on grievances and resolution.<sup>21</sup>

*Grievances and the quality measurement and improvement process.* Since grievances and appeals are part of quality measurement and improvement, it is important to tie the results of the process back to the quality improvement system. This means provision of information regarding the type and frequency of adverse decisions and the basis for such decisions, the frequency and disposition of grievances, timelines for resolution as well as the resolution itself, and information on the process used and information and assistance furnished to members, especially members with additional representational needs related to language spoken or diminished capacity.

These various policy statements can be distilled into a series of measurements for a fair grievance and appeals process:

- *Scope of the grievance system:* A decision that is available in the case of any decision to deny, delay, reduce, limit, or terminate treatment, or that requires the use of medical judgment, regardless of the specific basis for the denial that is stated in the notice of denial (e.g., medical necessity versus exclusion or non-coverage).
- *The timing and content of notices:* Notices of adverse decisions both at the time of the initial adverse decision and at each subsequent stage of the review process. To be fair the notice must be readable and must provide a detailed explanation of the action to be taken, the company's basis of authority for taking the action, and the rationale for the action. It is not enough to simply tell the member that care will be denied. The member needs to know why the care will be denied and the basis of authority for the company to deny the care (e.g., it is not covered under the contract). Additionally, the initial notice, which may well be the most important, must explain appeals rights, where and how to file an appeal, and the assistance, if any, that will be made available.
- *Timelines for initial decisions:* When dealing with an initial decision on a request for treatment or following concurrent review of ongoing treatment, a grievance system should consider whether care is furnished in accordance with a timeline that meets the

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<sup>21</sup> *Id.*

exigencies of the case (e.g., 14 days for non-urgent requests, 72 hours for urgent requests).

- *General assistance in navigating the grievance and appeals process:* The ability to have representation at various stages of grievances and appeals.
- *Assistance at all stages of the initial decision and grievance process for persons whose primary language is not English:* Readability considerations, as well as federal civil rights laws, make access to readable notices essential. Where possible, notices should be in the languages spoken by members. All notices should indicate where and how to obtain interpretation assistance, as well as general assistance at all stages of the grievance.
- *Notice in the case of persons with diminished capacity and disabilities that affect ability to communicate effectively:* Given the health status of Medicaid beneficiaries generally, as well as the requirements of federal civil rights laws for persons with disabilities, it is necessary to make reasonable modifications in the notice and hearing process to accommodate the needs of persons with disabilities. This means notification of guardians (where present) and authorized representatives (where known) and the inclusion of information in all notices regarding where and how persons with disabilities can obtain assistance.
- *The appropriateness of the reviewer:* Fundamental fairness requires that internal reviewers have the necessary and relevant knowledge and expertise, have not been involved in the initial decision, and have no financial interest in the resolution of the decision. Furthermore, reviewers need to be knowledgeable about the terms of the agreement between the MCO and the agency so that they have a clear understanding of what is covered and under what circumstances.
- *The conduct of the review:* A review must consider all relevant and reliable medical evidence in the case, including the member's medical record, the opinion of the treating clinician, the appropriateness in light of the individual's condition of practice guidelines used by the MCO, and any evidence regarding medical or health status that the member elects to furnish.
- *Decision timelines:* Decision timelines must be consistent with the medical exigencies of the case (e.g., in non-urgent cases 30 days from the time of the request of the review and 72 hours in the case of denials that in the opinion of the patient's provider involve urgent care).
- *Communication of the decision:* Decisions must be accompanied by a written document that explains the decision in readable terms, sets forth the basis for the conclusion, and explains further appeal rights.
- *Notification of other payers:* The system should include a means for communicating the results of the grievance to other potential payers who may cover the benefit for the individual, with information to the member regarding how to seek review from other sources of coverage.

- *Additional grievance safeguards for other types of disputes:* Grievance or complaint procedures are also needed for other types of disputes that do not directly implicate the availability of treatment.

### Part 3. Current State Approaches to Grievance Procedures

Several studies in recent years have considered state managed care consumer protection laws, and at least one study has examined selected state grievance practices.<sup>22</sup> However, there never has been a comprehensive review of existing Medicaid managed care grievance procedures, nor do the state consumer studies measure the extent to which insurance protections are extended to Medicaid beneficiaries enrolled in managed care.<sup>23</sup> This lack of information regarding the Medicaid grievance process is important in light of questions regarding the potential for duplication between fair hearing and grievance processes.

To more closely assess state Medicaid grievance procedures, we examined the contracts in the 1999 data base for *Negotiating the New Health System*. While this data base has limitations for this type of study (for example, it would not necessarily indicate the application of more generalized statutes), it offers comprehensive information regarding contractor grievance obligations. Contracts typically also refer to state consumer protection laws of general applicability, as well as relevant state and federal regulations.

*Negotiating the New Health System* summarizes certain basic grievance and appeal information at Table 6.2. This table shows that all states require their contractors to maintain grievance systems, and that nearly all specify explicitly that there is a right of appeal to the state as part of the process.<sup>24</sup> Most impose certain timelines on the process. However, the contracts vary in the degree of specificity with which they describe the process required of contractors. A majority of the contracts provide detailed specifications for some or all elements of the grievance procedure; the remainder either provide the contractors with the discretion to develop mechanisms or refer to grievance requirements that are applicable as a matter of state law to all MCOs.

Table 6.2 also addresses specifications for an expedited review process. Only 25 contracts, however, provide for an expedited process. The standards for “expedited” vary but tend to range between 2 and 4 working days. The following examples illustrate the degree of variability regarding what is meant by “expedited”:

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<sup>22</sup> See, e.g., Jane Perkins et al., *Ombudsprograms and Member Advocates: Consumer-Oriented Approaches to Problem-Solving in Managed Care* (National Health Law Program, Los Angeles, CA, 1998); and Joanne Rawlings-Sekunda, *Addressing Complaints and Grievances in Medicaid Managed Care* (National Academy for State Health Policy, Portland, ME, 1999).

<sup>23</sup> In many states, Medicaid managed care products are exempt from state insurance laws for a variety of purposes. Therefore, it cannot be assumed that consumer protection laws aimed at state-regulated insurers automatically apply to Medicaid managed care enrollees.

<sup>24</sup> It should be noted that regardless of whether the contract specifies the existence of appeals rights, managed care enrollees, like any Medicaid beneficiaries, have fair hearing rights, whose exact nature in a managed care context will be clarified by HCFA. An important issue, however, remains what the Medicaid agency tells its contractors, since contractors may be entirely unfamiliar with the fair hearing process. Furthermore, some agencies may elect to administer parallel appeals systems for grievances that function separately from a wholly independent fair hearing system (e.g., a state that has general laws establishing grievance and appeals systems for managed care enrollees, where appeals from grievances are heard by separate external reviewers).

The HMO shall respond to written complaints (i.e., formal grievances) in writing within 10 business days of receipt of grievance, except that in cases of emergency or urgent situations, HMOs must resolve the grievance within 4 business days of receiving the complaint, or sooner if possible.

Wisconsin Contract, *Negotiating the New Health System*, Table 6.2

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[A health plan must provide] a description of the complaint/grievance system [which] at a minimum ensures that clients have the right to an expedited complaint/grievance formal hearing within 24 to 48 hours regarding any denial, termination, or reduction of services which could place the recipient at risk or which seriously jeopardizes the client's health or well-being.

Delaware RFP, *Negotiating the New Health System*, Table 6.2

In order to examine the issue of grievance elements for cases involving medical treatment in greater depth, we undertook a more detailed examination of the contract provisions. For this examination, we developed a table that sets forth additional indicators of adequacy. These indicators are based on the work of the Quality Commission, Congress, HCFA, and the courts. We also examined the contracts to determine whether contractors are required to notify Medicaid beneficiaries of their fair hearing rights.

The results of this review are presented in Table 1 at the end of this Issue Brief. Checkmarks indicate that the issue is addressed to *any* degree as part of the contract.

Table 1 indicates that states' contracts contain specifications for some of the indicators selected for review. Certain key indicators are addressed to only a limited degree or not at all.

#### *Definition and scope of the grievance obligation*

As noted, all contracts require contractors to have a grievance system. However, only 21 out of 52 contracts define what constitutes a decision that gives rise to a grievance right. There is significant variation in the definitions that are used. Many states also distinguish "grievances"-- which tend to be more formal and include written requirements for their resolution--from more informal "complaints".

The following examples illustrate the range of approaches used to define the types of decisions that give rise to grievance rights:

Adverse determinations or non-certifications or admissions, continued stays, or services shall be clearly documented, including the specific clinical or other reason for the adverse determination, and shall be available to the Member and affected provider.

Colorado Contract, *Negotiating the New Health System*, Table 6.2

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Right to complain/grieve

Any \*\*\*client has the right to file a complaint/grievance \*\*\* if dissatisfied with the actions taken with respect to their care. A \*\*\* grievance is defined as follows: \*\*\* A written request for resolution by a client who is dissatisfied with the services received from the MCO.

Delaware Contract, *Negotiating the New Health System*, Table 6.2

\* \* \*

The health plan shall establish a grievance and appeals process that shall guarantee the right for a fair hearing to any member whose claim for medical assistance is denied, reduced, inappropriate to meet needs, or not acted upon promptly by the health plan or the state agency.

Missouri Contract, *Negotiating the New Health System*, Table 6.2

\* \* \*

The partnership shall have a timely and organized formal grievance system in place \* \* \* . The grievance process will be available for disputes between the Partnership and the Member concerning, among other things, denial, reduction or termination of services; requests for services that are not acted upon in a timely manner; dissatisfaction with providers; appropriateness of services rendered; availability of services; the inability to obtain culturally and linguistically appropriate care; or disputes regarding disenrollment. A denial includes any instances in which a request for a medical service or Medicaid eligibility has been made in which a member has been told “no.”

Kentucky Contract, *Negotiating the New Health System*, Table 6.2

Of these four examples, Missouri comes the closest in its grievance definition to the range of treatment actions that also give rise to fair hearing rights (the Missouri contract also gives beneficiaries the right to select among both a grievance and a fair hearing remedy from the point at which the initial adverse decision is made). Kentucky’s grievance system extends beyond those actions that trigger fair hearing rights and include quality and availability matters, as well as issues related to language and cultural competence. All four of these examples cover the full range of adverse decisions, regardless of whether the basis for the adverse decision is a lack of medical necessity or some other grounds for denial.

*Notice of initial decision: timing and content*

Nearly all of the analyzed contracts require contractors to describe the grievance procedures to members, typically at the time of enrollment and as part of the enrollee handbook. Of particular significance, however, is the fact that only 21 out of 52 contracts specify that notice of the right to file a grievance be given at the time of a managed care decision that is classified as appealable. Because only a minority of contracts require notice of grievance rights at the time that an appealable action is taken, this may be a significant factor in the relatively low number of grievances reported by some states.

Two states that illustrate the contrast in approaches are Michigan and Minnesota. Michigan’s contract contains a general specification regarding notice of the availability of a grievance system but is silent regarding notice when a specific grievable action occurs. Minnesota, on the other hand, is quite specific regarding when the notice must be given. Nothing in Michigan’s contract would require an MCO to state the member’s rights at the

time that an adverse event occurs. MCOs are obligated to respond to grievances but are not obligated to disclose their availability at the time of the treatment decision.

The health plan will establish an internal process for the resolution of complaints and grievances from \*\*\* members. Members may file a complaint or grievance on any aspect of service provided to them by the health plan or the health plan's contract providers. \*\*\* The health plan will \*\*\* provide designated staff to receive, investigate and resolve complaints and grievances.

Michigan Contract, *Negotiating the New Health System*, Table 6.2

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If the health plan denies, reduces or terminates medical services requested by an enrollee or ordered by a participating treating [health provider] the health plan must notify the enrollee in writing of the following: (a) a statement of what action the health plan intends to take; (b) the type of service that is denied/terminated/reduced; (c) the reason(s) for the intended action; (d) the specific federal or state regulations and health plan policies that support or require the action; (e) an explanation of the enrollee's right to request an evidentiary hearing \*\*\* with both the health plan and the state, the right to appeal to the state \*\*\* without first exhausting the health plan complaint procedure, and the right to a second opinion.

Minnesota Contract, *Negotiating the New Health System*, Table 6.2

Where notice at the time of action is required, the contract typically further specifies the content of the notice itself, as the Minnesota contract excerpt displayed above indicates, although there is considerable variation in the extent of the specifications that are furnished.

#### *Reviewer capabilities and authority*

Federal regulations require that the grievance be heard by an individual with the authority to order corrective action. Twenty contracts repeat this specification. Fewer than five contracts, however, specify reviewer capabilities such as the lack of involvement in the initial decision, medical knowledge, or relevant expertise.

For example, both New Mexico's and Florida's general contracts specify that "the plan shall have physician involvement in reviewing medically-related grievances." (*Negotiating the New Health System*, Table 6.2) However, no medical knowledge (not even at a generalized level) is specified in the case of grievance reviewers under Florida's behavioral health contract who are examining medical judgment-related grievances.

Maryland's regulations governing its managed care program offer what may be the most extensive provisions regarding the capabilities of reviewers in the case of mental health-related cases:

In order to provide a procedure to hear, investigate, and resolve grievances regarding denial of services, SMHS shall ensure that mental health professionals responsible for these determinations include at a minimum a (a) psychiatrist who is privileged to evaluate the type of service under review and who shall \*\*\* document a determination based on medical necessity about the denial, and (b) medical director, who is a psychiatrist and who shall, upon the \*\*\* individual's or provider's request, review and document a determination to deny [care].

Maryland Contract, *Negotiating the New Health System*, Table 6.2

*Conduct of the review*

Only four out of fifty-two contracts address to any degree the actual conduct of the review itself, including the evidence to be considered and the decision-making procedures to be used. Missouri's contract offers an example of limited specifications related to the conduct of the review itself:

Health plans must thoroughly investigate each grievance using applicable statutory, regulatory, and contractual provisions, as well as the health plan's written policies. All pertinent facts from all parties must be collected.

Missouri Contract, *Negotiating the New Health System*, Table 6.2

In addition, few contracts address the required contents of a written resolution to the grieving beneficiary. Such contents could include the facts established in relation to the grievance, the basis for the determination, and the appeal procedures available to the beneficiary.

*Notice of fair hearing rights*

Twenty-eight out of fifty-two contracts specify that the contractor inform members of their fair hearing rights. In half of these cases, recipients are given the option to proceed through the fair hearing process from the beginning. In the remaining contracts, the right to a fair hearing is conditioned on the exhaustion of the internal grievance system. This practice is used even in contracts that may not specify a grievance process that contains all of the elements required under federal fair hearing regulations. For example, Mississippi's contract specifically conditions access to a hearing before the state agency on exhaustion of all HMO appeals (Mississippi Contract, *Negotiating the New Health System*, Table 6.2).

A significant aspect of the Medicaid fair hearing process is that if a fair hearing is requested in a case of benefit reduction (i.e., within 10 days of the notice to terminate or reduce benefits), then benefits must be continued at pre-notice levels.<sup>25</sup> Nine states appear to require their contractors to continue benefits pending the outcome of either the grievance or the fair hearing (DE, MN, MT, NV, NE (behavioral health contract), NC, NJ, OR (behavioral health contract), and OK).<sup>26</sup>

*Assistance and access to evidence*

Twenty-four out of fifty-two contracts specify that members have a right to assistance in carrying out a grievance. Only a subset of these contracts provide that members have a right to review the evidence used by the managed care organizations. Washington State's mental health contract specifies that

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<sup>25</sup> 42 C.F.R. §431.230.

<sup>26</sup> Assistance pending the resolution of an appeal that is filed in a timely fashion is a basic requirement under the fair hearing regulations.

[s]ervice recipients shall receive, at minimal cost, written recipient information which they and/or their representatives (including Ombuds Services) may request for fact finding/filing/resolving complaints and grievances.

Washington Behavioral Health Contract, *Negotiating the New Health System*, Table 6.2

One form of assistance to enrollees with mental illnesses and other disabilities is a state's protection and advocacy (P & A) system. The first P & A legislation was enacted as part of the Developmental Disabilities and Bill of Rights Act in 1975; subsequent legislation expanded the program to cover persons with mental illness,<sup>27</sup> as well as other persons with serious mental health conditions and other conditions that do not require institutionalization.<sup>28</sup> In Pennsylvania, as a result of litigation, the state P & A agency receives copies of all notices of denials, reductions, and terminations of benefits within 14 days of the time that the HMO mails the notice to the member. The P & A agency can then represent the member. (Interestingly, the state's standard contract itself appears to make no mention of this obligation to mail the notices.)

Another form of assistance is ombudsprograms. Several of the contracts specify the availability of ombudspersons. While some advocacy groups raise a cautionary note regarding the use of ombudsprograms,<sup>29</sup> the existence of such a program may be an additional resource for obtaining assistance with a grievance.

#### *Recordkeeping and reporting*

Thirty-three out of fifty-two contracts specify that the contractor must maintain a record of the hearing and report the results to the agency. One of the most interesting contracts in this respect is the Oregon behavioral health contract, which specifies:

Upon receipt of an expedited Complaint or \* \* \* hearing request, the Contractor representative or Division representative who received the request shall immediately notify other payers with an interest in the issue and begin collecting relevant documents.

Oregon Contract, *Negotiating the New Health System*, Table 6.2

Because this notification occurs at the beginning of the review rather than after its completion, the state has the opportunity to bring all payers together – itself, its behavioral health plan, and its general plan – to resolve the dispute where one of the issues is the ultimate liability of a payer for coverage at all.

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<sup>27</sup> 42 U.S.C. §10801 et seq.

<sup>28</sup> 29 U.S.C. §794(e) et seq. See generally Gary Gross, *Protection and Advocacy System Standing to Vindicate the Rights of Persons with Disabilities*, 22 MPDLR 5 (Sept./Oct., 1998).

<sup>29</sup> *Ombudsprograms and Member Advocates*, op. cit. The National Health Law Program reports that ombudsprograms operate in California, Michigan, Minnesota, Oregon, Tennessee, Vermont, and Wisconsin. Interestingly, some, but not all, of the contracts from these states specifically mention the contractor's relationship obligations with the ombudsprogram, raising questions related to the accessibility of MCO information and resources to ombudspersons who are attempting to assist members.

## Conclusion

This analysis reports on the elements of a managed care grievance system that have been identified over the past several years and compares current state Medicaid contract specifications to these elements. This analysis also suggests that states currently maintain grievance systems that appear to possess some, but not all, of the elements that have been identified part of a workable grievance system. Particularly notable are the lack of consistent requirements related to the standards regarding what actions give rise to grievance rights, adequate notice of action and grievance rights at the time of initial determination, the capabilities of the reviewers, and the actual conduct of the review itself.

These omissions are notable, since at least some states also appear to limit access to fair hearing procedures until the grievance procedure has been exhausted. While fair hearings do not include expedited procedures for urgent conditions, they do provide for continuation of benefits in termination or reduction cases pending the outcome of the hearing. This obviously is an extremely important safeguard for persons with physical and mental disabilities who otherwise would face the loss of treatment during the pendency of a grievance.

Another area of importance is the relative lack of assistance for persons with disability-related limitations. About half of all contracts specify some level of assistance (e.g., clerical support to handle the paperwork); a few specify the availability of an ombudsperson or other more active form of assistance. In general, however, enrollees appear to be expected to navigate the system on their own.

States have several obvious interests in making grievance systems effective. A well-functioning grievance system may be important for member satisfaction. To the extent that states elect not to permit their members access to the fair hearing process until the grievance process has been exhausted, an improved grievance system would appear to be quite important. A well-functioning grievance system that allows ready access to a thorough appeals process is also a means for “real time” quality assurance, since individual claims can be aggregated and studied across plans to identify potential areas of quality-related problems. Finally, grievance procedures that allow for rapid review and decision making may avert injuries that could result in litigation against a state.

As with other areas of managed care policy development, the state contracts reveal widespread variation in provisions and standards. Some of this variation is a natural outgrowth of the differences in the process used by states. But other variations may simply be a consequence of insufficient understanding of how to structure a grievance procedure. Final HCFA regulations may provide important clarifications for states to include in their contracts. In addition, this would appear to be an ideal area for the development of sample purchasing specifications once the final regulations appear.