

Meeting Summary
Appeals/Grievances/Complaints Improvement Team
April 20, 2001 10:30 – 1:30pm
Kaiser Permanente, Oakland, California

Team Members Attending:

Marilyn Ammons - KFHP
 Emily Awkerman – Scripps Clinic
 Tina Bridgeport – NCQA
 Veva Caldera – InterCommunity Services
 Gloria Canfield – HCFA
 Inda Chow – Aetna
 Cathy Jaegge – Phys. Asso of San Gabriel Valley
 Joy Johnson - DMHC
 Andrea Kmetz – Marin IPA

Debra Mullins – DHS
 Leanne Ripperger – Pacificare
 Paula Robinson – Hill
 Toni Schiavo – HealthNet
 Marggie Swartz – Western Center on Law and Poverty
 Tracy Solis – Bright Medical Associates
 Kathy Tamashiro – Blue Cross
 Kristine Thurston – NCQA
 Patty McGinnis – HealthNet

By Phone: Kathleen Bloomer, Erin Perek – Monarch

Also Attending: David Hopkins, Diane Stewart - PBGH

Purpose: To review work to date, and review agency standards and proposed work plan.

Topics	Comments and Conclusions
Project Background Appeals/Grievances/Complaints Goals and Timeline	<ul style="list-style-type: none"> • DMHC formal comment likely to close in early July. • Implementation plan should consider how to influence stakeholders not present, including MRMIB and Local Initiatives. • It was felt that some plans not represented may have broader or differing definitions of appeals and grievances.
Oversight Agency Requirements	Issues in current system: (DMHC's definition of Grievance used here to apply to any and all appeals, complaints, re-considerations) <ul style="list-style-type: none"> • The plans and provider groups do not always communicate effectively about the work that they are doing to resolve member complaints. Because of this it is believed that the case logs of grievances from health plans and groups generally do not match • However, it was noted that the logs may not match because some grievances address only plan issues (i.e. benefit offerings) which may be appropriate. • Some plans provide more detailed logs to the groups that help them identify grievances relevant to their responsibilities • Some groups report that plans deduct overturned

Topics	Comments and Conclusions
	<p>denials from cap payments without notification or documentation of appeal</p> <ul style="list-style-type: none"> • Group advises patient to contact plan about a grievance; no way to be sure patient follows through • Group says that many seniors will not pursue an appeal with the plan on their own • Some groups want to handle grievances to provide better service to patients • One group reports that some cap deductions result from plan's inability to meet timeframes (instead of meeting timeframes, the plan will overturn a group's denial) • Some plans won't accept notification from group, only the member. This causes a delay in getting the complaint reviewed timely or even cause the concern to not get reviewed at all if the member chooses not to call the plan. * • Some groups expressed a wish to have plans delegate portions of grievance process to groups • One plan suggests only 10% of groups are capable of performing well under delegation of grievances • Denial letters now must have specific language about reason for denials, including references to benefit language if applicable as well as separate language for each regulatory agency which creates increasing demands on group systems
Proposed Process changes	<ul style="list-style-type: none"> • Plans accept grievances and appeals reported or filed by the provider groups on behalf of the members • Provider groups must submit complaints to the plan within 24 hours from their receipt
Key Issues/Areas to Improving the Process	<ul style="list-style-type: none"> • Improving initial grievance process between the group and the plan • Improving member's experience with group/plan in the grievance process
Engagement/Communication Plan	Deferred
Requirements Clarifications	<ol style="list-style-type: none"> 1) *HCFA allows groups to pass appeals from members on to plan 2) DMHC Regulation 1300.68 "The grievance system shall be established in writing and provide for procedures that will receive, review and resolve within 30 calendar days of receipt by the plan, or any entity with delegated or contracted authority to administer the plan's grievance system"

Topics	Comments and Conclusions	
Work to complete before next meeting	<ul style="list-style-type: none"> • Submit 2 service grievances and 2 appeals (denials of service, benefit or payment). Oversight agency team members send 4 sent to external review. Fax to Kristine 415-281-0960 • Check on start date of grievance originating at a groups holding Knox-Keene license 	<p>All team members.</p> <p>Johnson</p>

Next Meeting: Friday May 5th 10:00am to 1pm at HealthNet's Teleconferencing Centers in Woodland Hills and Oakland, California.

Purpose:

- Review grievances provided by plans and groups following first meeting.
- Analyze processes used and timeframes for resolving grievances.
- Identify commonalties and variances and opportunities for streamlining in the initial phase of the grievance process.