Increasing Consumer Power in the Grievance and Appeal Process for Medicare HMO Enrollees

Kenneth J. Pippin

University of Michigan Law School

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Federal law requires that Health Maintenance Organizations (HMOs) and Managed Care Organizations (MCOs) provide Medicare beneficiaries with specific grievance and appeal rights for challenging adverse decisions of these organizations. The Health Care Financing Administration (HCFA) is charged with enforcing these regulations. Currently, however, HCFA contracts with HMOs, allowing them to enroll Medicare beneficiaries despite the fact that many of the statutory and regulatory requirements are ignored by the Medicare HMOs. This is problematic because the elderly Medicare population may not be able to independently and adequately challenge the HMO's denial of care or reimbursement. Because HCFA has been reluctant and ineffective in ensuring that Medicare enrollees are guaranteed grievance and appeal rights, other alternatives should be explored. This Note argues that private accreditation, for those Medicare HMOs that choose to be subjected to the process, should be allowed as an alternative to regulation under HCFA.

"The . . . [grievance and appeal process] used by the HMOs hides the ball."

Increasing numbers of the elderly are enrolling in Medicare Health Maintenance Organizations (HMOs) or other Competitive Medical Plans (CMPs) rather than the traditional fee-for-service Medicare program. In 1993, there were 2.1 million Medicare beneficiaries enrolled in HMOs, totaling 6% of the Medicare population. By 1999, the number of Medicare recipients enrolled...
in HMOs increased to seven million or 17% of the Medicare population.4 The Balanced Budget Act of 1997 provides further incentives for Medicare beneficiaries to enroll in HMOs.5 The Congressional Budget Office estimates that in four years 25% of all Medicare beneficiaries will be enrolled in HMOs.6 Often HMOs are attractive to both the beneficiaries, because they receive benefits beyond those provided by the fee-for-service Medicare option,7 and the U.S. government, because HMOs provide care to the enrollees on a capitated basis, resulting in lower expenditures for the public Medicare program.8

There is a concern among health care observers, however, that because HMOs receive capitated payments for their enrollees and have an interest in maximizing profits, HMOs have incentives to reduce the number of services provided and to supply inferior care.9 One way to address this concern is to design and implement a functioning grievance and appeal mechanism for HMO enrollees who believe they have been denied medically necessary services

0015dack.asp> (on file with the University of Michigan Journal of Law Reform). The discussion in this Note focuses on the elderly, those people aged sixty-five years and older who therefore are covered by Medicare. Although other individuals, including the disabled, may be covered by the Medicare program, the elderly comprise an overwhelming majority of Medicare recipients.


7. See Peter D. Fox & Teresa Fama, Managed Care and the Elderly: Performance and Potential, 20 GENERATIONS 31, 33 (1996) (stating that Medicare HMOs often save enrollees money and provide "imaginative services... that Medicare would not normally pay for"). Examples include screenings for chronic illness to promote early intervention, providing more extensive primary care to reduce emergency room and hospital visits, arranging transportation programs for people with mobility problems and altering the home environment to reduce the risk of falls. See id.

8. See Pi-Yi Mayo, Medicare Health Maintenance Organizations, 39 S. TEx. L. REV. 25, 26 (1997). Under the traditional fee-for-service model, there is no limit to the number of services Medicare beneficiaries can receive and accordingly no limit to the amount of money the Medicare program may spend. Under the Medicare HMO model, the Medicare program pays a fixed amount to the Medicare HMO for each Medicare HMO enrollee. Generally, the budget is fixed regardless of how many services are provided to the enrollees. See id. at 27–28.

9. See id. at 28–29 ("[A] possible desire on the part of an HMO to spend as little per enrollee in order to turn a profit... causes some advocates to be concerned that health care decisions may be made on the basis of economics rather than on the beneficiary's health care needs.").
that have been purportedly guaranteed under the Medicare program or their HMO's plan. Currently, Medicare HMO enrollees may exit their plan at any time, but beginning in 2002 under the Medicare+Choice Program, which is an expansion of managed care in the Medicare program, they must wait six months before disenrolling; this waiting period will increase to nine months starting in 2003. As the waiting period to disenroll from Medicare HMOs grows longer, a meaningful grievance and appeal process will become more important to the beneficiaries because it will be one of the few ways an enrollee can advance his right to receive care or protest poor treatment.

As a condition of payment from the Health Care Financing Administration (HCFA), which administers Medicare, an HMO must show that its plan “provide[s] meaningful procedures for hearing and resolving grievances between the organization . . . and members enrolled with the organization under [the Medicare Program].” Unfortunately, under the current system of enforcement, HMOs often fail to provide meaningful grievance and appeal processes. Furthermore, HCFA has done little to sanction these non-compliant HMOs.

For example, in 1992, HCFA found a California HMO to have breached the requirement to provide adequate notice to enrollees. In 1994, the violations were still taking place. After a review of the case, HCFA observed that the HMO lacked the time and

13. See infra Part II.B.
14. See infra Part III.
16. See id.
resources to implement the grievance and appeal rules.\textsuperscript{17} This inability directly conflicts with the statute, which requires every Medicare HMO to have a meaningful grievance and appeal process.\textsuperscript{18} HCFA found that in 62\% of reviewed cases the California HMO failed to forward appeals for redeterminations to HCFA within the sixty day administrative requirement.\textsuperscript{19} Even though HCFA found the HMO committed numerous violations and the HMO issued only corrective action plans on paper with few changes in its administration, HCFA nevertheless approved the Medicare contract each time, despite the HMO’s non-compliance with the statute and the regulations.\textsuperscript{20} During this time the HMO tripled its Medicare membership even though beneficiaries did not receive their appeal rights.\textsuperscript{21}

This example demonstrates HCFA’s failure to ensure that the vulnerable population of Medicare HMO enrollees has access to a functioning grievance and appeal process.\textsuperscript{22} Because the grievance and appeal process is potentially an enrollee’s strongest tool in dealing with his HMO, the process needs to be effective. Because HCFA does not enforce these regulations adequately, the Medicare HMO enrollee is at a disadvantage in filing complaints and addressing denials of his care. Therefore, other methods of regulation should be explored. Private accreditation of Medicare HMOs as an alternative to HCFA approval is one way to protect consumers and provide them with better information on Medicare HMOs.

This Note argues that the U.S. Congress and the Department of Health and Human Services should allow Medicare HMOs to seek voluntary accreditation from government-certified private organizations in lieu of direct government regulation of their internal grievance and appeal processes. Voluntary accreditation would improve HMO efficiency and provide more information to Medicare enrollees. Part I of this Note provides an overview of the current Medicare HMO grievance and appeal process. Part II describes the behavior of the elderly as health care consumers. Part III describes how the current lack of enforcement of government regulations

\textsuperscript{17} See id.
\textsuperscript{18} See 42 U.S.C. § 1395mm (c)(5)(A) (1994).
\textsuperscript{19} See U.S. General Accounting Office, supra note 15, at 13. A redetermination is a request by an enrollee to the HMO to reconsider a decision to deny a type of treatment or other medical decision. See 42 C.F.R. § 417.614 (1999).
\textsuperscript{21} See id.
\textsuperscript{22} See infra Part II.B (providing numerous examples of HCFA’s failure to enforce the grievance and appeal requirements for Medicare HMOs).
results in the need for alternate forms of regulation in the area of grievance and appeal. Part IV proposes solutions that strengthen the grievance and appeal process for Medicare HMO enrollees. Part V explains how voluntary private accreditation of an HMO’s grievance and appeal process would operate and concludes that, among the available choices, a voluntary private accreditation mechanism would best inform and protect Medicare HMO enrollees.

I. CURRENT STATUTORY AND REGULATORY REQUIREMENTS GOVERNING THE PROCESS OF GRIEVANCE AND APPEAL FOR MEDICARE HMOs

For an HMO to enroll Medicare beneficiaries and receive payment from HCFA, the HMO must “provide meaningful procedures for hearing and resolving grievances between the organization . . . and members enrolled with the organization under [the Medicare Program].”23 Enrollees may challenge an HMO decision if they are “dissatisfied because they do not receive health care services to which they believe they are entitled, at no greater cost than they believe they are required to pay.”24 The HMO must establish procedures for appeals, which allow enrollees to dispute specific determinations by the HMO, and grievances, which facilitate enrollees’ general complaints.25 If an HMO does not comply with these requirements, HCFA can terminate its Medicare contract26 or impose civil fines.27 To explain the current grievance and appeal process, a brief explanation of the terms used throughout follows.

An organization determination is a determination by an HMO regarding any medical treatment.\textsuperscript{28} Organization determinations may be appealed.\textsuperscript{29} For example, a Medicare enrollee may appeal an HMO's denial of any type of treatment, such as a specific medical procedure, a hospital stay, or a specialist visit. If an organization determination conflicts with the preferences of the Medicare enrollee, it is characterized as being "adverse."\textsuperscript{30}

A grievance is defined as a challenge to a "determination that is not an organization determination."\textsuperscript{31} If, for example, a Medicare enrollee wanted to challenge the method of filing claims with the HMO because it is time-consuming and delays reimbursement, the challenge would be considered a grievance because the HMO did not make an adverse organization determination with respect to the enrollee.

The HMO must "ensure that all enrollees receive written information about the grievance and appeals procedures . . . available . . . to them."\textsuperscript{32} This information must detail a beneficiary's grievance and appeal rights, the circumstances required for expedited review, the actions required by the beneficiary, and the time limits for each stage of review.\textsuperscript{33} The HMO must also provide information explaining how the enrollee may activate the independent Peer Review Organizations (PROs) that review the appropriateness of hospital discharges under the Medicare program.\textsuperscript{34}

If an HMO makes an adverse organization determination regarding an enrollee, the HMO must notify the enrollee within sixty

\textsuperscript{28} See 42 C.F.R. § 417.606(a)(1)-(4) (1999). This includes "[p]ayment for emergency or urgently needed services," any other services furnished by a provider other than the HMO that the "enrollee believes [a]re covered under Medicare; and [s]hould have been furnished, arranged for, or reimbursed by the HMO," the refusal of services that the enrollee believes should be furnished by the HMO, and discontinuation of a service, such as skilled nursing care, that the enrollee believes should be continued. \textit{Id.; see also} 42 C.F.R. § 417.606(b) (1999) (defining actions that do not qualify as HMO determinations as determinations regarding services that were furnished by the HMO for which the enrollee has no obligations and those subject to a grievance procedure as defined in 42 C.F.R. § 416.606 (1999)).


\textsuperscript{30} See 42 C.F.R. § 417.608(a) (1999) (stating that an HMO must provide notice to an enrollee when it makes an organization determination that is partially or fully adverse to the enrollee).

\textsuperscript{31} 42 C.F.R. § 417.606(c) (1999) (explaining that grievances are defined in terms of not rising to the level of organization determinations).


\textsuperscript{34} See 42 C.F.R. § 417.606(b)(4) (1999); \textit{see also} 42 C.F.R. § 417.605 (1999) (describing the immediate PRO process through which a determination of non-coverage for inpatient hospital care is reviewed by a special committee of physicians that evaluates the care plan and its appropriateness).
days of its receipt of the enrollee's request for care or the provision of services. Failure to provide timely notice constitutes an adverse organization determination and may be appealed automatically. The notice must include "the specific reasons for the [adverse organization] determinations" and must "[i]nform the enrollee of his or her right to a reconsideration [of an adverse organization determination], including the right to and conditions for obtaining an expedited [reconsideration by the HMO]."

An expedited reconsideration is allowed only if the organization determination "could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function." The HMO must notify the enrollee, and the physician if appropriate, of the outcome of the reconsideration. This must be done within seventy-two hours of the enrollee's request, but an extension can be made by the HMO for ten working days if the HMO determines that additional information is necessary and the delay is not injurious to the enrollee's interests. The HMO must provide the appellee a "reasonable opportunity to present evidence and allegations of fact or law, related to the issue in dispute, in person as well as in writing."

Once an enrollee has exhausted the HMO's internal procedure of appeals for adverse determinations, he may turn to the existing appeal procedures provided under the Medicare program. If after this review the HMO partially or wholly affirms the adverse

37. 42 C.F.R. § 417.608(b) (1999); see also 42 C.F.R. § 417.616 (1999) (describing how an individual may seek reconsideration of an adverse organization determination of the HMO).
38. See 42 C.F.R. § 417.609 (1999). The Medicare HMO enrollee may request the review either in writing or orally. See 42 C.F.R. § 417.609(a).
39. 42 C.F.R. § 417.609(b) (1999) (stating that the HMO decides which determinations fall into this category).
organization determination, it must explain that decision in writing to HCFA, which contracts with an independent group, the Center for Health Dispute Resolution (CHDR), to review the HMO's determinations.

After this process concludes, an enrollee who is still dissatisfied has the right to a hearing before an administrative law judge (ALJ). Any party to the ALJ hearing may appeal to the Departmental Appeals Board (DAB) to review the ALJ's decision or dismissal. Finally, the enrollee has the right to judicial review in federal district court if the amount in controversy exceeds $1000.

The structure of the grievance and appeal process for Medicare HMOs can be confusing to enrollees. HCFA's lack of enforcement of existing regulations further diminishes the power of the elderly consumer. When structuring a new regulatory method, it is important to consider the actual behavior of and problems faced by older Americans in the health care marketplace. Part II examines these issues.

II. Elderly Health Care Consumers Face Information Problems When Interacting with HMOs

The characteristics of Medicare enrollees, especially as they differ from the entire population of health care consumers, affect the success of the Medicare grievance and appeal system. Although Congress created the Medicare program in the 1960s, the introduction of managed care often makes evaluation of and access to HMOs difficult. This Part reviews how Medicare beneficiaries un-

43. See 42 C.F.R. § 417.620(b) (1999).
45. See 42 C.F.R. § 417.600(a)(2)(ii)(A) (1999); 42 C.F.R. § 417.630 (1999). The amount in controversy must be $100 or greater and a request must be filed within 60 days of the notice of the determination. See 42 C.F.R. § 417.600(a)(2)(ii)(A); 42 C.F.R. § 417.630.
46. The Departmental Appeals Board is an administrative body originally established under the Social Security Act and has been utilized in resolving disputes under Medicare. See Procedures of the Departmental Appeals Board, 45 C.F.R. § 16 app. A (1997).
47. See 42 C.F.R. § 417.634 (1999) (stating that any party that is dissatisfied with the determination may appeal to the Social Security Administration Appeals Council to review the DAB's decision).
nderstand their health care options and how they perceive their rights when enrolled in HMOs. Part II.A reviews the characteristics and knowledge of Medicare beneficiaries. Part II.B discusses the difficulties Medicare HMO enrollees experience in advancing their interests once they have joined an HMO.

A. Characteristics and Knowledge of Medicare Beneficiaries

Consumers have difficulty in assessing managed health care plans.49 One commentator wrote, "[c]onsumers are and will remain technically unable to assess, unguided, the relative quality [and availability of medical care]."50 This is particularly true with respect to the elderly enrollee.51 A study released by the American Association of Retired Persons (AARP) found that 89% of Medicare beneficiaries did not have enough knowledge to make an informed choice between traditional fee-for-service Medicare and Medicare HMOs in areas of high geographic concentration of managed care options.52

Similarly, in another survey consisting of half Medicare HMO enrollees and half Medicare fee-for-service beneficiaries, only 11% of those surveyed had adequate knowledge (scores of 76% or higher on a set of questions) to choose between traditional Medicare and an HMO.53 More than 59% of those surveyed fell in the "inadequate" range (scores of 50% or less).54 Finally, 11% scored in the lowest quartile.55 Those who scored in the lowest quartile were more often female and enrolled in an HMO, used fewer information sources, had less education, and had a lower income level than those in the highest quartile.56

These statistics raise concerns about whether the elderly have a diminished ability to advocate for themselves against the corporate

51. See infra Part II.B.
52. See AARP, supra note 6 (stating that when they make choices about whether to join an HMO, the elderly often are inadequately informed and, for example, often do not understand which services an HMO would cover).
54. See id.
55. See id. (stating that those who scored in this category answered fewer questions correctly than had they guessed).
56. See id.
HMO. The authors of the survey stated, "[i]t appears that those . . . who used information from consumer groups and newspapers or magazines had significantly higher knowledge scores than those who did not use these sources.\textsuperscript{57} Information is difficult to obtain, especially because "[f]ew, if any enrollees routinely read the Federal Register for noncompliance notices [of an HMO's failure to comply with certain regulations], and revocation of an HMO's federal qualification is rare."\textsuperscript{58} The information problems related to assessing the quality of HMOs indicate the need for measures aimed at protecting the elderly consumer.

Suspiciously, regardless of what type of Medicare coverage beneficiaries choose all of the respondents reported satisfaction with their health care services.\textsuperscript{59} One study concluded, "[Medicare] HMO enrollees were significantly more likely than nonenrollees were to be very satisfied with the costs of care and with getting all of their care at one location."\textsuperscript{60} However, the authors pointed out that even though Medicare beneficiaries are generally satisfied with the care they receive, the high percentage of satisfied enrollees could be due to dissatisfied enrollees deciding to exercise their ability to disenroll, returning to the fee-for-service option.\textsuperscript{61} This observation may be further reinforced by the study’s finding that HMO enrollees were less likely than those in Medicare fee-for-service programs to strongly agree with positive statements about their care.\textsuperscript{62}

In a review of several surveys of Medicare beneficiaries, the authors evaluated a National Academy of Social Insurance (NASI) study.\textsuperscript{63} They found that their own research was consistent with data from Medicare focus groups conducted in the past five years.\textsuperscript{64} Throughout the studies, "beneficiaries . . . had difficulty understanding or comparing the plan options available to them."\textsuperscript{65} Also, "there was a widespread perception, reflected in all of the sessions

\textsuperscript{57.} Id.
\textsuperscript{59.} See Cynthia G. Tudor et al., Satisfaction with Care: Do Medicare HMOs Make a Difference?, HEALTH AFF., Mar.-Apr. 1998, at 165, 166.
\textsuperscript{60.} Id. at 170.
\textsuperscript{61.} See id. at 174.
\textsuperscript{62.} See id. at 173.
\textsuperscript{63.} See Jill Bernstein & Rosemary A. Stevens, Public Opinion, Knowledge and Medicare Reform, HEALTH AFF., Jan.-Feb. 1999, at 180, 181.
\textsuperscript{64.} See id. at 184.
\textsuperscript{65.} Id.
with seniors, that when beneficiaries enroll in a Medicare managed care plan, they are no longer 'in Medicare.'”

B. Medicare HMO Enrollees Face Problems in Asserting Their Rights Under the Current Grievance and Appeal Process

Various characteristics of Medicare HMO enrollees, including, for example, their lower incomes, raise concerns about their ability to advocate for themselves when an HMO makes a determination that is adverse to their interests. The regulatory structure governing how HMOs design their grievance and appeal process should account for this problem. Unfortunately, the current regulations have not been sensitive to some of the particular vulnerabilities of Medicare enrollees.

The information problems for Medicare beneficiaries persist once they enroll in an HMO, particularly with respect to the grievance and appeal process. One survey found that many elderly Medicare HMO enrollees were unaware that the Medicare grievance and appeal process continued to apply to them after they joined an HMO. Several participants believed incorrectly that “'when you join a health plan, you are no longer in Medicare, and you can't change plans for a year.'” One quarter of the beneficiaries in a government study did not know they had the right to appeal their HMO’s refusal to provide or pay for services. This is consistent with the study discussed earlier that found appeal rights were poorly understood.

Unfortunately, those in fair or poor health and the oldest elderly are much more likely than the general population to report access problems in Medicare HMOs, including difficulties in protesting adverse organization determinations. Congress, in enacting and amending the Medicare Act, “has repeatedly recognized that the elderly, as a group, are less able than the general population to deal effectively with legal notices and written

66. Id.
67. See id.
68. Id.
70. See Hibbard et al., supra note 53; see also Bernstein & Stevens, supra note 63.
registration requirements."

In a review of several social science studies, Marc A. Rodwin wrote, "[d]ue process standards assume that consumers will use grievance processes, if available. Individual consumers, however, often lack the resources, the stamina, or the inclination to do so."

One of the consequences of Medicare beneficiaries' inability to advocate strongly on their own behalf is that they disenroll from Medicare HMOs at a significant rate. Statistics show that a substantial number of Medicare HMO enrollees return to Medicare's fee-for-service option. By one national sample, 16% of the elderly in Medicare HMOs cease to be members of an HMO in any given year. The General Accounting Office (GAO) determined that Medicare HMO enrollees disenroll from HMOs at greater rates than the general population. Disenrollment may be indicative of dissatisfaction with care and frustration in advancing their claims against HMOs.

Further statistics provide insight on how Medicare HMO enrollees currently appeal adverse determinations made by their HMO. The Network Design Group (NDG) and the CHDR compile statistics on the number and type of appeals filed by enrollees. "NDG resolved almost 2500 of 3704 reconsiderations filed during 1992." NDG reported that between 1989 and 1992 the number of reconsiderations increased from 1.7 to 2.2 cases per 1000 enrollees; this was faster than the enrollment growth rate. In 1996, CHDR reviewed reconsiderations of decisions by Medicare HMOs. Only the plans with at least 1000 enrollees were considered in the review. On average, only 1.1% of enrollees requested reconsideration of adverse organization determinations. Very few Medicare enrollees exercised their right to advance an appeal.

73. Rodwin, supra note 10, at 1347 (citing scientific studies of consumers fearing reprisal from providers and showing that consumers do not know the appeal procedures).
74. See infra notes 75–76 and accompanying text.
75. See Fox & Fama, supra note 7, at 33.
76. See U.S. General Accounting Office, supra note 15, at 14 (stating that in 1991 42% of Medicare enrollees disenrolled from their HMOs within two years following a dispute over covered services, and, of those, 63% disenrolled 90 days after their cases were decided by HCFA).
77. See Scanlon, supra note 44 and accompanying text.
78. Stayn, supra note 58, at 1696 n.150.
79. See id.
81. See id.
82. See id.
Of all the NDG decisions, 58% supported the HMO, 8% of the appeals were withdrawn, and 33% were successful.\(^8\) A minority of the appeals were resolved in favor of the Medicare enrollee. Of the successful appeals, 60% completely overturned the HMO's adverse determination, 15% partially overturned the adverse determination, and 24% resulted in the enrollee's retroactive disenrollment from the HMO, which shifted the responsibility for payment to the Medicare fee-for-service program.\(^8\) Nearly 60% of all sampled cases involved disputes over emergency or urgent services.\(^8\) In 1992, appeals most commonly concerned HMO denial of payment for treatment by outside providers (many cases arose when there were long delays for specialists); emergency care; and unauthorized inpatient care.\(^8\) The mean value per claim for cases processed in 1992 was $900 for treatment by an outside doctor, $680 for emergency care, and $11,998 for inpatient care.\(^8\) The cost of these services may discourage the enrollees from personally incurring them and thus results in inadequate care. There were very few appeals for reconsideration of adverse organization determinations of HMOs by enrollees. One commentator has suggested:

[O]ne reason that the appeal system may not be serving as effective a deterrent purpose as it might is that more than one-third of Medicare HMOs report no reconsideration requests. While it is possible that outstanding performance explains the lack of any appeals in these plans, a perhaps more plausible explanation is that enrollees are poorly informed of appeal rights and procedures.\(^8\)

More recent data, based on the 4552 reconsiderations reviewed by CHDR, shows that 65.5% of the reconsiderations were upheld and 28.5% were overturned.\(^9\) The remaining 6% were either partially overturned or reconsideration was not completed because the person disenrolled.\(^9\) Reconsiderations based on nonpayment of care (when the enrollee received care from a provider outside the

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83. See Stayn, supra note 58, at 1696 n.150.
84. See id.
85. See id.
87. See id. at 1697 n.159.
88. Id. at 1696 n.152 (citation omitted).
89. See Perspective: Medicare HMO Appeals Process Becomes Top Concern for HCFA, Consumers, supra note 80.
90. See id.
network) were upheld in 66.6% of the cases in 1996.\textsuperscript{91} Reconsiderations based on denials of coverage for inpatient hospital care were overturned in 43.2% of all cases in favor of the enrollee.\textsuperscript{92} A Medicare HMO enrollee typically will not advance an appeal for the denial of a certain treatment or medical expense. Enrollees who do advance claims will likely be unsuccessful.

The data show that very few appeals are ever advanced by Medicare HMO enrollees and most of the claims reviewed by the independent reviewer are affirmed in favor of the HMO.\textsuperscript{93} It is difficult for enrollees and their families to navigate through the grievance and appeal process for two reasons. First, it is unlikely that enrollees even know the process exists. Second, even if they do, enrollees likely find the process difficult to understand. The lack of appeals made by enrollees illustrates that Medicare enrollees are not using the grievance and appeals process and that "weak government oversight has allowed this to persist."\textsuperscript{94} HMOs have been able to exploit the combination of vulnerable enrollees and the lack of HCFA enforcement. HCFA has failed to ensure that Medicare HMO enrollees understand that they may attempt to overcome adverse decisions by appealing them. In order to relieve the difficulties facing Medicare HMO enrollees in advocating for themselves, it is critical that the grievance and appeal process be improved.

### III. Medicare HMO Enrollees’ Difficulties Require an Alternate Form of HMO Regulation

Despite the existence of regulations that govern the grievance and appeal process of Medicare HMOs, "studies by government and advocacy groups have consistently identified a wide gap between regulatory standards and actual practices."\textsuperscript{95} HCFA has repeatedly failed to enforce regulations relating to the grievance and appeal process for Medicare HMO enrollees.\textsuperscript{96} Part III.A discusses the recent litigation prompting HCFA to issue rules to

\begin{itemize}
\item \textsuperscript{91} See id.
\item \textsuperscript{92} See id.
\item \textsuperscript{93} See supra text accompanying notes 71–92.
\item \textsuperscript{94} Stayn, supra note 58, at 1696 n.152.
\item \textsuperscript{95} Tracy E. Miller, Center Stage on the Patient Protection Agenda: Grievance and Appeal Rights, 26 J.L. MED. & ETHICS 89, 90 (1998) (showing that regulations have yet to materialize into real enforcement from the enrollee’s perspective).
\item \textsuperscript{96} See supra Part I (discussing regulations for MCOs, including HMOs).
\end{itemize}
review an enrollee’s appeal more quickly. Part III.B summarizes the criticisms of HCFA’s regulation of the grievance and appeal processes of Medicare HMOs.

A. HCFA Protests Order to Enforce Medicare HMO Grievance and Appeal Compliance

A Medicare HMO refused to cover seventy-two year-old Gregoria Grijalva’s nursing-home care after she had been hospitalized for chronic health problems.77 She never received notice that the HMO was denying coverage for the nursing home care and her attorney stated that Grijalva “never knew that there was an appeals process.”78 Grijalva sued HCFA for contracting with HMOs that did not administer their grievance and appeal process according to the Medicare Act and regulations developed pursuant to the Act.79 The suit developed into a class action of “all persons, nationwide, who were enrolled in Medicare risk-based health maintenance organizations or competitive medical plans during the three years prior to the filing of [the] lawsuit.”80 The plaintiff class sought declaratory and injunctive relief against the Secretary of Health and Human Services, Donna Shalala (Secretary), for “abdicating her responsibility to monitor HMOs and to ensure that HMOs provide Medicare covered benefits.”81 The class demanded further that the Secretary “implement and enforce effective notice, hearing, and appeals procedures for HMO service denials.”82 The court granted the plaintiffs’ motion for summary judgment and ordered the Secretary to enforce the service provisions that require Medicare HMOs, under the Due

98. Id.
99. See id.
100. Grijalva v. Shalala, Civ. No. 93-711 TUC ACM, 1995 WL 523609, at *7 (D. Ariz. July 18, 1995) (ordering certification of the class action). There were two sub-classes. The first included those persons denied services by an HMO, with or without notice, who presented a claim to the Secretary by seeking reconsideration of the HMO denial or by filing some other form of appeal or objection with the HMO, HHS/HCFA, or SSA office and whose claims were not administratively resolved. The second group included persons who were not given adequate notice or appeal rights, including those persons whose claims were favorably adjudicated by HHS/HCFA. See id.
102. Id.
Process Clause, to provide notice when services are denied.\textsuperscript{103} The service provisions require the HMO to hold an expedited hearing before denying services that could harm an enrollee.\textsuperscript{104} The Ninth Circuit Court of Appeals affirmed the order because the Medicare Act mandates that the Secretary “may not enter into a contract . . . with an [HMO]” unless the HMO meets all the requirements under the Act.\textsuperscript{105}

The court relied on the extensive documentation of actual appeals presented by the plaintiffs.\textsuperscript{106} The plaintiffs reviewed 570 HMO notices of adverse determinations and analyzed them according to the following categories:

1. \textit{Readability}: 52\% of the notices reviewed were illegible, based primarily on criteria of 12-point type as the recognized minimum print size for readability by elderly persons.

2. \textit{Reason for Denial}: 74\% of the notices provided vague, ambiguous, nonspecific reasons for denial.

3. \textit{Personal Liability}: only 41\% contained an explanation of personal liability resulting from care incurred subsequent to denial.

4. \textit{Appeal Rights}: \textit{[a]} vast majority of the notices provided information on appeal rights. Ninety-six percent of the notices included the time frame for appeal; 91\% directed claimants on where or with whom to file the appeal; 73\% explained that additional evidence could be provided; only 10\% provided information about Peer Review Organization (PRO) review.\textsuperscript{107}

Furthermore, “[i]n 25\% of the notices reviewed by Plaintiffs, or in eight of the ten reviewed by the Court, the HMO failed to inform the claimant that he or she had a right to present additional evidence to the HMO for reconsideration.”\textsuperscript{108} The court further found that the notices did not inform enrollees that they could turn to

\textsuperscript{103} See id.

\textsuperscript{104} See id. at 754; see also supra notes 38–41 and accompanying text.

\textsuperscript{105} Grijalva v. Shalala, 152 F.3d 1115, 1124 (9th Cir. 1998) (citing 42 U.S.C. § 1395mm(c)(1)), vacated, Grijalva v. Shalala, 119 S. Ct. 1573 (1999) (vacating the Ninth Circuit’s decision and remanding with instruction that the decision be made in accordance with American Manufacturers Mutual Insurance Co. v. Sullivan, 119 S. Ct. 977 (1999), as well as the relevant statutes and regulations).

\textsuperscript{106} See Grijalva, 946 F. Supp. at 757–58.

\textsuperscript{107} Id. (footnote omitted) (citing Volume III Plaintiff’s Exhibit C in Support of Motion for Summary Judgment, at 2). Yet very few Medicare HMO enrollees know their rights to appeal. See supra Part II.B.

\textsuperscript{108} Grijalva, 946 F. Supp. at 758.
their physician for support in advocating their position and to develop potential evidence to use in an appeal.°9

Two factors were critical in the court's decision: first, the negative effect on enrollees resulting from the great length of time required to resolve appeals; and, second, the lack of notice from HMOs that an adverse determination had been made. The court wrote, "[g]iven the length of time it takes for further appeal of the HMO denial [of service], deprivations [in care] will certainly have significant impacts on [an enrollee's] quality of life and some may even be life threatening."°10 The court reasoned that to have a meaningful opportunity to present evidence under the Due Process Clause enrollees must have that opportunity within a reasonable period of time.°11 Additionally, the court discussed how Medicare beneficiaries would be especially harmed because many live near the poverty line; the effect of not receiving the care denied by the HMO would be great for those enrollees because physical harm or death could result.°12 On appeal, the Ninth Circuit agreed, writing that "[t]he mere fact that the enrollee may be able to go elsewhere and pay for the services herself is of little comfort to an elderly, poor patient—particularly one who is ill and whose skilled nursing care has been terminated without a specific reason or description of how to appeal."°13

On certiorari to the U.S. Supreme Court, the Court vacated the decision of the Ninth Circuit and remanded the decision to be in accordance with American Manufacturers Mutual Insurance Co. v. Sullivan.°14 The Court in American Manufacturers held that the statutory scheme in Pennsylvania that permitted a utilization review committee to deny workers' compensation claims for health expenses did not violate due process because the private insurers, who could request utilization review, were not state actors.°15 The Court stated that the test of whether the Due Process Clause had been violated required "both an alleged constitutional deprivation 'caused by the exercise of some right or privilege created by the State or by a rule

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°9. See id. (finding also that this violated 42 C.F.R. § 417.618, which requires HMOs to allow enrollees to present evidence when advancing their appeal).

°10. Id. at 750.

°11. See id. at 759 (citing Gray Panthers v. Schweiker, 652 F.2d 146, 164 (D.C. Cir. 1980)).

°12. See id. at 756–57.


of conduct imposed by the State or by a person for whom the State is responsible,' and that 'the party charged with the deprivation must be a person who may fairly be said to be a state actor.'"

The lower courts likely will find that the Due Process clause was violated in *Grijalva*. First, a constitutional deprivation exists for Medicare HMO enrollees when care has been denied. The Court in *American Manufacturers* explained that for a Due Process right to be triggered the plaintiff must have been denied a protected interest in property or liberty. The Court provided numerous examples of protected property interests, such as federal welfare assistance and Social Security benefits. Explaining that the workers' compensation benefits provided for only "reasonable" and "necessary" expenses, the Court reasoned that they were not a protected interest because, differing from welfare and social security, they did not entitle an employee to the payment of all medical treatment. The receipt of Medicare benefits, including those from an HMO, is more akin to universal programs such as Social Security and welfare. For example, all people over the age of sixty-five have the right to receive specific health care services, such as emergency care services. These rights to care and for the payment of these medical treatments, such as emergency care, do not terminate without due process once a Medicare beneficiary chooses to receive care from an HMO rather then the fee-for-service plan.

Second, on remand, the Medicare HMOs may be held to be state actors. The *American Manufacturers* Court overruled the reasoning of the Third Circuit that state-mandated benefits provided by private insurers did not constitute state action. In distinguishing a case where the Court found state action and one in which the state was constitutionally obligated to provide medical treatment to injured inmates, the Court explained that the State of Pennsylvania was not obligated to provide benefits because the legislation placed the obligation on the employers. As applied to health benefits for Medicare beneficiaries, the obligation is on the government to pay for these services. Whether the beneficiary received health care

116. *Id.* at 985 (citations omitted).
117. *See id.* at 989 (citing U.S. CONST., amend. XIV and Matthews v. Eldridge, 424 U.S. 319, 332 (1976)).
118. *See id.* at 990 (citing Goldberg v. Kelly, 397 U.S. 254 (1970) and Matthews v. Eldridge, 424 U.S. 319 (1976)). The Court stated that the issue, similar to that of HMO enrollees, is "whether predeprivation notice and a hearing were required before the individual's interest in continued payment of benefits could be terminated." *American Mfrs.*, 119 S. Ct. at 990.
119. *See id.*
120. *See id.* at 987–88.
through the fee-for-service or HMO option, the federal government is the payor of those services. Each Medicare HMO receives a per capita payment for each enrollee. The obligation, therefore, is on the federal government, as a state actor, to pay for those services. In addition, the American Manufacturers Court explained that state action exists when “the State 'has exercised coercive power or has provided such significant encouragement, either overt or covert, that the choice must in law be deemed to be that of the State.’”122 In the case of Medicare HMOs, Congress is encouraging and providing incentives, through the Balanced Budget Act, to have more Medicare beneficiaries enroll in Medicare HMOs. With such encouragement by the state to provide Medicare benefits through Medicare HMOs, it is likely that the lower court will issue a similar decision that the denial of care by private Medicare HMOs constitutes state action. Therefore, even though the Supreme Court vacated the Ninth Circuit’s decision, the case will likely be decided and reasoned on similar grounds on remand.

In practice, Congress and HCFA have created requirements for Medicare HMOs that require due process for Medicare HMO enrollees when care or payment for services is denied. However, instead of enforcing existing regulations against the non-compliant Medicare HMOs, the Secretary, somewhat surprisingly, fought the Grijalva suit.123 The Secretary argued that “Medicare enrollees in HMOs exchanged Medicare appeal rights for expanded [Medicare].”124 Additionally, the Secretary claimed that because HMOs are private organizations, the Due Process Clause of the Fourteenth Amendment did not apply.125 The district court disagreed, finding that the Due Process Clause applied to private entity decisions, such as those made by hospitals and physicians under fee-for-service Medicare.126 The district court ultimately found that “the Medicare statute, the Secretary’s regulations, and the Due Process Clause of the Constitution, unequivocally provide that a

123. See Grijalva v. Shalala, 946 F. Supp. 747, 758 (D. Ariz. 1996), aff’d, 152 F.3d 1115 (9th Cir. 1998), vacated, 119 S. Ct. 1573 (1999). This position is surprising because the Secretary would likely want to institute measures that protect consumers rather than leave them vulnerable.
124. Id. at 753 n.8.
125. See id. at 751 (claiming that private actors, such as HMOs, were not covered by the Due Process Clause and therefore did not have to provide HMO enrollees with the same procedural protections that they would receive from government actors).
126. See id. at 752–53 (stating that, although the HMOs were private actors, they provided government benefits which enrollees had a right to receive and, therefore, were public actors covered under the Due Process Clause).
Medicare beneficiary is entitled to notice and hearing when an HMO denies services based on [organization] determinations.\textsuperscript{127} Applying the prior analysis of American Manufacturers, the private Medicare HMOs are state actors because the federal government is obligated to pay for the health care costs of Medicare HMO beneficiaries.\textsuperscript{128} In violation of the statute and regulations, the court emphasized that Congress expressly prohibited the Secretary from entering into arrangements with HMOs that did not meet the statutory requirements, including the grievance and appeal requirements.\textsuperscript{129} On appeal, the Ninth Circuit stated, "[t]he Secretary fails to recognize the real problem: Inadequate notice renders the existence of an appeal process meaningless."\textsuperscript{130} Both the district and appeals courts found that, in addition to violating a Medicare beneficiary's right to due process, the statute and regulations were not being enforced by HCFA. The district court listed ten minimum standards for the form and content of the notice and other requirements for a hearing.\textsuperscript{131} A subsequent order of the court added that the notice must be prompt and that an expedited process must be available when services are urgently needed.\textsuperscript{132} After the district court granted partial summary judgment for the plaintiffs and issued the injunction, the Secretary promulgated new regulations.\textsuperscript{133} These new rules permit an enrollee to request an expedited review for a denied service within seventy-two hours if a longer wait could jeopardize life or health.\textsuperscript{134}

The Grijalva cases show that HCFA has been both ineffective and reluctant in enforcing the Medicare HMO regulations as they pertain to grievance and appeal rights of enrollees. When it becomes necessary for enrollees to sue the Secretary to receive their rights—rights unambiguously provided for under the statute and regulations—questions arise as to HCFA's effectiveness. These

\begin{itemize}
  \item[127.] Grijalva, 946 F. Supp. at 755 (footnotes omitted).
  \item[128.] See supra notes 120-22 and accompanying text; see also Note, Medicare Managed Care: A New Constitutional Right to Due Process for Denials of Care Under Grijalva v. Shalala, 28 Hofstra L. Rev. 185, 220-23 (1999) (analyzing Grijalva in accordance with American Manufacturers).
  \item[129.] See Grijalva, 946 F. Supp. at 760-61 (stating that HCFA violated 42 U.S.C. § 1395mm(c)(1)).
  \item[130.] Grijalva v. Shalala, 152 F.3d 1115, 1122 (9th Cir. 1998), vacated, 119 S. Ct. 1573 (1999).
  \item[131.] See Grijalva, 946 F. Supp. at 760-61 (stating conditions including minimum point size for notices and requirements that the notice be prompt).
  \item[133.] See Grijalva, 152 F.3d at 1124.
  \item[134.] See Clark, supra note 97, at 112; supra notes 38-41 and accompanying text (discussing statutory requirements for expedited review).
\end{itemize}
questions include serious concerns about the due process rights of enrollees, many of whom are unable to advocate effectively for themselves. These concerns will only grow in importance as Congress continues to encourage Medicare beneficiaries to enroll in HMOs.

B. Despite Repeated Warnings, HCFA Fails to Regulate the Grievance and Appeal Process of Medicare HMOs

Many governmental studies and health care advocates have noted that the Secretary had not effectively enforced the grievance and appeal laws for Medicare HMOs. The district court accurately assessed that "HMOs hide the ball" from enrollees when playing the game of appealing HMO adverse determinations. Commentators generally do not endorse the current procedures and the level of enforcement. Numerous studies by government agencies and contractors, both before and after the Grijalva decision, have issued warnings to HCFA, but HCFA took few enforcement actions. As a result, an enrollee is unable to combat the powerful interests of the HMO and encounters difficulty in obtaining information regarding the efficacy of an HMO's grievance and appeal processes when initially choosing an HMO.

The GAO has been one of the harshest critics of HCFA's oversight of Medicare HMO compliance with the grievance and appeal requirements. According to the GAO, Medicare HMOs often

136. See, e.g., Gordon Bonnyman Jr. & Michele M. Johnson, Unseen Peril: Inadequate Enrollee Grievance Protections in Public Managed Care Programs, 65 TENN. L. REV. 359, 374 (1998) ("[T]he Medicare HMO appeal process is of practical use only in contesting the retrospective denial of a claim for services already rendered. Even then, its value is limited due to the difficulty of persuading a clinician to provide care in the face of HMO's refusal of coverage."); Miller, supra note 95, at 91 ("[T]he Medicare experience demonstrates the need for explicit policies to govern the appeal process and an effective strategy for implementation and enforcement."). But see Statement of Jim Parkel, Member AARP Board of Directors, on Medicare Appeals, Presented to the Health Subcommittee on Ways and Means of the U.S. House of Representatives, April 23, 1998 (visited Apr. 2, 2000) <http://www.aarp.org/wwstand/testimony/1998/testparkel.html> [hereinafter Parkel] (on file with the University of Michigan Journal of Law Reform) ("On balance, we give the Medicare managed care appeal process high marks. Compared to what is available in private sector managed care, the Medicare appeal process remains the gold standard, despite its shortcomings.").
137. See infra Part III.B.
138. See supra Part II.A–B.
139. See infra note 157 and accompanying text.
distribute "inaccurate or incomplete benefit information" to their elderly consumers.\textsuperscript{140}

The GAO recently conducted a study of several HMOs and found that the benefit materials distributed by sixteen HMOs reported incorrect information regarding the specific services that the HMO provided and the parties that must approve care.\textsuperscript{141} The GAO found that many beneficiaries did not receive the required information when their HMOs denied services or payment for services.\textsuperscript{142} Often the HMO would give little prior notice when it denied coverage.\textsuperscript{143} In its analysis, the GAO cited previous investigations of HCFA which found many violations.\textsuperscript{144} The GAO reviewed the notices sent to enrollees by the HMO and found them incomplete, vague, missing, or even never issued.\textsuperscript{145} In fifty-three of the seventy-four CHDR cases that contained the required denial notices, the notices simply said that the enrollee did not meet the coverage requirements or they contained some other vague reason for the denial; advocacy groups reported similar concerns to the GAO.\textsuperscript{146}

When enrollees are presented only with incorrect or vague information, they face great difficulty in effectively appealing adverse organization determinations.

In commenting on Medicare HMOs' failure to administer the program in a fair manner, the GAO stated that for some HMOs:

\begin{itemize}
\item[140.] McGinley, \textit{supra} note 4, at A4.
\item[141.] \textit{See} Scanlon, \textit{supra} note 44, at 5–7 (listing as an example the approval necessary to receive a mammogram).
\item[142.] \textit{See id.} at 11.
\item[143.] \textit{See id.}
\item[144.] \textit{See id.} at 11–12. The GAO report further states:
\begin{quote}
In 1997, HCFA performed monitoring visits to 90 MCOs and about 13 percent of these MCOs were cited for failing to issue denial notices. In addition, nearly one-quarter of the 90 MCOs were cited for issuing denial notices that did not adequately explain beneficiaries' appeal rights. Two studies by the [Office of the Inspector General], using different methodologies, provide additional evidence that beneficiaries are not always informed of their appeal rights.
\end{quote}

\item[145.] \textit{See id.} at 12 (arguing that "[appeal notifications] contain general, rather than specific reasons for the denial").
\item[146.] \textit{See id.} 
\end{itemize}
[The] general practice was to issue the denial notices the day before the services were discontinued. We found that many skilled nursing facility [SNF] discharge notices were mailed to the beneficiary's home instead of being delivered to the facility. In other cases, it appeared that the beneficiary or his or her representative received the notice a few days after the beneficiary had been discharged from the SNF or the SNF coverage had ended. Ten of the 25 SNF discharge cases we reviewed at CHDR also involved the receipt of notice after the patient had been discharged.\(^\text{147}\)

When HCFA evaluates HMOs for their accuracy of notification to enrollees when denying treatment, it compares the notices with plan information that often is incorrect, resulting in HCFA finding compliance where none exists.\(^\text{148}\) Also, HCFA does not generally check cases where an enrollee did not appeal the denial of services or reimbursement.\(^\text{149}\)

Currently, HCFA is developing model literature for grievance and appeal disclosure information, with completion by the fall of 1999 and testing during 2000.\(^\text{150}\) Yet it is not clear what the practical effect of these materials will be. The GAO stated:

To date, however, [HCFA's] policies and practices have fallen short of [the] mark . . . . We believe . . . that [despite HCFA initiatives] these problems will not be fully addressed until HCFA implements our past and current recommendations by setting information standards for MCOs and requiring them to adhere to those standards.\(^\text{151}\)

Additionally, the Balanced Budget Act requires HCFA to develop comparative HMO information for consumers, but as of this

\(^{147}\) Id. at 12.

\(^{148}\) See id. at 13. For example, HMOs have informed beneficiaries in their plan's benefits that a mammogram requires physician approval while this practice is prohibited under Medicare. See McGinley, supra note 4, at A4.

\(^{149}\) See Scanlon, supra note 44, at 14 (stating further that when the HMO contracts with other organizations to issue denial and appeal letters, HCFA does not check these materials and that HCFA only reviews those cases that are appealed and does not investigate whether an enrollee who is denied services receives notice).

\(^{150}\) See id. at 15. HCFA is developing model literature that may be distributed by HMOs to enrollees. It is thought that this information will assist enrollees in better understanding their rights in the grievance and appeal process.

\(^{151}\) Id. at 16.
writing, consumers must primarily rely upon information distributed by the HMO.\textsuperscript{152}

As for sanctioning HMOs that commit violations of the statutes and regulations, HCFA has frequently failed to act. In 1995, the GAO found that HCFA's enforcement actions against Medicare HMOs were weak.\textsuperscript{153}

When HCFA has documented problems in HMOs that have been slow to correct deficiencies, it has been reluctant to use sanctions and other enforcement tools at its disposal. Under HCFA's enforcement approach, serious improprieties by a few Medicare HMOs—subjecting beneficiaries to abusive sales practices, unduly delaying their appeals, or exhibiting patterns of poor quality of care—have taken years to resolve.\textsuperscript{154}

In particular, the GAO found that the appeal process for beneficiaries was unnecessarily slow; beneficiaries who appealed denials often waited six months or more for resolution.\textsuperscript{155} The GAO wrote:

Although intended to be a beneficial protection against potential underservice by HMOs, the appeal process is too slow to effectively resolve disputes over services that beneficiaries believe are urgently needed. Moreover, some HMOs have extended the process even more by not processing beneficiaries' appeals within the prescribed time frames. This results in some beneficiaries returning to fee-for-service Medicare to obtain the services they believe they need, while others remain in HMOs but incur substantial out-of-pocket expenses with little certainty of repayment.\textsuperscript{156}

Numerous other GAO reports have chronicled HCFA's failure and issued warnings.\textsuperscript{157}

\textsuperscript{152} See id. at 1. But see HCFA, Operational Policy Letter, supra note 42 (advising HMOs how to submit appeals data, but not providing information, such as ALJ claims, beyond initial determinations).


\textsuperscript{154} Id.

\textsuperscript{155} Id.

\textsuperscript{156} Id. at 13–14.

Other government agencies and organizations have made similar recommendations concerning HCFA’s failures in this area. After analyzing the appeal claims HCFA submitted for its review in 1993, the NDG suggested that HCFA should focus corrective action on dispute-prone areas, improve HMO communications with enrollees, and design a national system for benefit denial appeals. A report filed by the Department of Health and Human Services (HHS) stated that Medicare HMO enrollees cannot obtain medical services because health plans have limited the ways in which members may appeal unfavorable decisions. June Gibbs Brown, Inspector General of HHS, said that “many HMOs—more than half of those examined—did not fulfill federal rules for handling appeals and grievances.” Furthermore, AARP has recorded cases where formal denial is delayed indefinitely or never communicated to the enrollee, or the reason given for a denial is meaningless. Most enrollees do not know, and are not told, that they have an absolute right to an expedited appeal if a doctor says that delay could be medically harmful.

Weak government oversight by HCFA has allowed these conditions to persist.

Despite such problems, HCFA historically has not employed its power to sanction Medicare HMOs. Although Congress first provided HCFA the authority to sanction in 1986, HCFA did not issue regulations implementing this authority until 1994. Because they were unable to rely on government oversight, private groups have worked to guarantee higher levels of quality in HMOs, helping to compensate for HCFA’s shortcomings.

\[158. \text{See David Richardson et al., Network Design Group, Inc., Study of Coverage Denial Disputes Between Medicare Beneficiaries and HMOs 4–5 (1993).}\]


\[160. \text{id.}\]

\[161. \text{Parkel, supra note 136.}\]

\[162. \text{See Stayn, supra note 58, at 1696 n.152.}\]

\[163. \text{See U.S. General Accounting Office, supra note 15, at 12.}\]

\[164. \text{See id. at 4.}\]
In conclusion, HCFA has not ensured that Medicare HMO consumers possess adequate information on how to appeal adverse HMO determinations and has neglected to act affirmatively to assist enrollees in successfully bringing and winning appeals. Again and again, HCFA has tried to regulate HMOs in this area and yet has not improved the situation for enrollees. Another method is needed because of HCFA's inability or reluctance to protect consumers and provide them with information. Private nongovernmental organizations offer both a stronger method of enforcement and better consumer information for Medicare HMO enrollees.

IV. PRIVATE ACCREDITATION OF THE MEDICARE GRIEVANCE AND APPEAL PROCESS AS AN ALTERNATIVE TO HCFA RULES AND ENFORCEMENT

Based on the current enforcement of the law and regulations for the protection of Medicare HMO enrollees in the grievance and appeal process, other forms of regulating the grievance and appeal process should be explored. These alternatives should take into account the particular characteristics of the Medicare population. This Part provides an introduction to this Note's proposed solution—permitting private accreditation of the grievance and appeal process for Medicare HMOs. Part IV.A discusses the goals that the regulation of the grievance and appeal process should achieve. Part IV.B outlines several proposed solutions for addressing the current problems in the grievance and appeal process. Part IV.C states the argument for private accreditation of Medicare HMOs as an alternative to HCFA regulation and introduces some organizations that may be able to conduct such accreditation.

A. Policy Goals

One of the greatest problems for health care consumers is that "[they] typically confront providers as individuals—a situation that usually pits unorganized diverse interests (consumers) against organized . . . interests."165 Reacting to this concern, Senator Charles Grassley, chairman of the Senate Special Committee on Aging,
stated that government oversight must be increased to give the elderly "‘the tools to choose’ the best health plan."\textsuperscript{166} Enhancing the typical Medicare HMO enrollee’s relative power in relation to her HMO is a critical part of improving the grievance and appeal process.

The AARP outlines five key elements necessary for a managed care appeal process which have general support from many consumer groups and scholars:

1. Speed.... Most treatment decisions should be made within a few weeks, and some within a few days, or even hours.\textsuperscript{167}

2. Notice and opportunity to be heard.\textsuperscript{168}....

3. Appropriate medical expertise [in making clinical decisions]....

4. Continuity of Care. This is a major concern for enrollees whose care is about to be terminated or reduced. It makes no sense to cut back on treatment, or to force a patient to leave a hospital, and then later decide that this was an error. In many cases, the care cannot be re-started, and where it can, the interruption in care may have caused serious and possibly irreversible harm. Treatment disputes in these cases should be resolved before any change in treatment occurs.

5. Outside independent review.\textsuperscript{169} A plan denial of medical care should be reviewed by someone having no relation to the plan and no stake in the outcome. Unbiased review is essential in a managed care environment

\textsuperscript{166} McGinley, supra note 4, at A4.

\textsuperscript{167} See also Clark, supra note 97, at 114 (explaining that despite the expedited appeal process, an enrollee, “can ask a doctor outside the network to request an expedited appeal, but [will] have to pay out of pocket for the consultation and may have to wait up to ten days—plus the 72 hours—for a decision”); Rother, supra note 10, at 42 ("[T]here is a compelling need to establish an appeals mechanism that can resolve denial treatment problems quickly and fairly."); Jonathan Gardner, HCFA Speeds Appeals of Denials of Care by Medicare Risk HMOs, MOD. HEALTHCARE, May 5, 1997, at 28 (reporting on the newly announced expedited appeal rules).

\textsuperscript{168} See also Eleanor D. Kinney, Consumer Grievance and Appeal Procedures in Managed Care Plans, HEALTH LAw., Jan. 1998, at 17, 20–21.

\textsuperscript{169} See also Kinney, supra note 168, at 20–21; Miller, supra note 95, at 92–93 (showing how many states are mandating some type of external review).
where the health plan's financial incentives may encourage saving money over delivery of appropriate, perhaps expensive, care.  

In addition, other consumer groups suggest that every process relating to grievance and appeal should somehow assist consumers in making decisions when choosing an HMO. These goals assist in evaluating the form and oversight of the grievance and appeal process for Medicare HMOs. The present form of regulation under HCFA does not meet these objectives because many Medicare HMO enrollees do not have notice and opportunity to advance their claims in a timely manner. In addition, enrollees often suffer interruptions in their care because of denials that force them back into fee-for-service Medicare.

B. Proposed Solutions

Several organizations advance solutions to better meet the needs and preferences of Medicare HMO enrollees. However, some organizations suggest that working within the current framework is best for enrollees. Unlike the AARP, some groups believe that the system of enforcing the grievance and appeal regulations does not require significant change and prefer to continue the current system with gradual reform. The first proposed solution suggests that although the current situation is not ideal, improvements could be made by simply codifying the grievance and appeal rights in greater detail or requiring the passage of mandatory statutory language or regulatory enforcement. The National Association of Insurance Commissioners (NAIC) has promulgated a model law that requires contracts between providers and HMOs to explicitly address grievance procedures and many states have enacted this

170. Parkel, supra note 136.
171. See McGinley, supra note 4, at A4; supra text accompanying note 166.
172. See Parkel, supra note 136 ("On balance, we give the Medicare managed care appeal process high marks. Compared to what is available in private sector managed care, the Medicare appeal process remains the gold standard, despite its shortcomings.").
173. For examples of federal bills proposed to regulate health care relationships and ensure the rights of managed care plan enrollees, see H.R. 1415, 105th Cong. (1997) and H.R. 2967, 105th Cong. (1997).
legislation. A second alternative, proposed by another commentator, is that the Medicare grievance and appeal process should be applied uniformly to all HMOs. This proposal is not an effective option for the elderly that need continuous care, "as the discontinuation of services during the lengthy appeal process is tantamount to a complete denial." This policy could be potentially quite expensive for the Medicare beneficiary, who would have to pay for the provided services during the appeal process.

A third way to encourage HMOs to respond to consumer concerns is to allow civil suits for all care determinations that negatively affect the enrollee. This option is poor for two reasons. First, it would protect consumers only after they have been denied care and that denial results in a negative outcome such as permanent disability or death. Such a solution does not promote a functioning grievance and appeal process for those enrollees who need prompt resolution of their care decisions. For them, filing a lawsuit after they sustain an irreparable injury is their only recourse. Second, except for the ability to determine which HMOs have been sued, this option would give potential enrollees little information upon which they can evaluate HMOs. The ability of Medicare enrollees to search for legal complaints against an HMO is limited and the process costly.

A fourth proposal dedicates more funding to the advancement of Medicare appeals and incorporates more professional ombudsmen. The authors of a study on grievance and appeal processes stated, "[i]ntermediaries (such as advocates, senior groups, family members, and health professionals) can play an important role in helping beneficiaries to understand their choices. However, the infrastructure for such outreach is underdeveloped and inadequately funded." In Texas, AARP, Families USA, and three nonprofit HMOs collaborated to develop principles to govern HMOs and agreed that a consumer ombudsman would help

175. See Stayn, supra note 58, at 1703 n.203.
176. See id.
177. Miller, supra note 95, at 90; see also supra notes 110–13 and accompanying text.
178. Currently, in some situations, these suits are preempted by ERISA. See Margaret G. Farrell, ERISA Preemption and Regulation of Managed Health Care: The Case for Managed Federalism, 23 Am. J.L. & Med. 251, 275 (1997) ("When beneficiaries of ERISA plans sue HMOs for injuries resulting from the negligence of an HMO-employed physician, their claims are treated as common law malpractice actions.").
179. See infra notes 180–82 and accompanying text.
enrollees navigate their plans. The Medicare Beneficiaries' Defense Fund (MBDF), a New York based advocacy group, wants to serve permanently as an advocate for HMO enrollees, evaluate the performance of HMOs, respond to telephone queries, and report on the kinds of problems members experience in different HMOs. This approach assumes that adequate funding exists for these programs and that consumer organizations exist to step into these areas. This, however, is not the case: funding is short, and consumer groups are understaffed and have few resources.

Each of the above proposals works within the current regulation and enforcement of grievance and appeal regulations. One commentator wrote that "[m]ost regulatory schemes impose uniform industry-wide rules that affect consumers across the board" and therefore provide a one-size-fits-all regulatory approach. But simply applying changes in statutory or regulatory language will not repair the inherent flaws in the current system of regulation. Consumers of health care "have diverse interests, needs, abilities, and values." Medicare recipients comprise a special group which needs its own advocates, such as private accreditors, to play an active role in designing HMO rules, ensuring HMO compliance with the grievance and appeal process, providing information to consumers, and advocating in individual cases.

C. Private Accreditation Provides Pre-Enrollment Information on HMOs and Empowers Enrolled Consumers in the Design and Operation of an HMO's Grievance and Appeal Process

1. Arguments for Private Accreditation of Medicare HMOs—Congress and HCFA should seek to bring consumer interests together to counter the size, specialization, and resources of the HMOs. Only in this way can the elderly be sufficiently protected in the Medicare HMO arena. A successful solution must "create institutions that help consumers organize or pool resources, expertise, purchasing power, information, or professional assistance." Private accreditation as an alternative form of compliance to the

183. Id. at 1374.
184. Id.
185. Id. at 1353.
HCFA regulations will better serve the Medicare HMO enrollees as well as assist HCFA in developing higher quality standards for the industry.

The proposals mentioned previously fail to encourage or allow non-governmental organizations to play a significant role in the design of rules for and the supervision of HMOs, thereby denying beneficiaries power. The consumer-oriented goals of a fast process that allows the individual to be heard without an interruption in care can be better addressed in an environment that allows private bodies to create alternative forms of regulation. Proposals for advocating the creation of an ombudsman address some of the current problems but require significant resources to enact. The ombudsman program also works within the current form of regulation and does not promote alternative solutions that may better meet the goals of the regulations. Additionally, as evidenced by the nursing home experience, even with an ombudsman to monitor providers, significant quality of care concerns remain.

Because HCFA has been reluctant to enforce Medicare HMO regulations and other proposals contain flaws that render them ineffective, Congress should enact legislation that permits Medicare HMOs to submit to private accreditation by government-certified accreditation bodies to satisfy federal requirements governing the grievance and appeal process. Private accreditation is the best way to protect those in Medicare who are denied care. Voluntary private accreditation allows the HMO to choose between standard government regulation under HCFA and the standards of government-approved private accrediting bodies. This Note argues that voluntary private accreditation will improve compliance and will increase the power of Medicare HMO enrollees.

Bodies that accredit health care providers are independent organizations that provide their approval as long as the health care provider meets the accrediting body's standards. Private accreditation serves two main purposes. First, it defines standards that

186. See infra Part IV.B.

187. See Jennifer L. Williamson, The Siren Song of the Elderly: Florida's Nursing Homes and the Dark Side of Chapter 400, 25 AM. J.L. & MED. 423, 426-27 (1999) (showing how regulations may have helped in some areas while at the same time significant abuses of the rights of nursing home residents occurred).

188. For a discussion of the advantages of self-regulation through a non-governmental entity, see generally Douglas C. Michael, Federal Agency Use of Audited Self-Regulation as a Regulatory Technique, 47 ADMIN. L. REV. 171 (1995) (analyzing advantages and disadvantages of audited self-regulation and private accreditation and concluding that this can be an effective regulatory scheme).
establish and measure quality; second, it determines whether the organizations seeking accreditation have met those standards. 189

There are many secondary benefits to private accreditation. The public costs of enforcement are reduced and those organizations seeking approval bear the costs of the accreditation process. 190 In addition, the accreditation organization "can develop superior knowledge of the subject when compared with the government agency, and self-regulation [involving private accreditation] allows for more diversity in methods of compliance with legal rules than a government agency can provide." 191 Voluntary private accreditation may result in better compliance because the organization chooses to be regulated in that particular manner. 192 Also, voluntary private accreditation gives more information to consumers. 193 This allows payors and consumers to make choices about HMOs in a shorter period of time and requires less investigation. Finally, private accreditation can be more flexible and innovative, allowing HMOs to meet their statutory obligations in a number of ways. Current command and control regulation dictates that only one method can be used to meet the regulatory requirements. 194 Under that design, the regulated entity must fulfill specific requirements and even though superior, or less costly methods could meet or exceed the goals of regulation, it is not permitted to take such action.


190. See Barry R. Furrow, Regulating the Managed Care Revolution: Private Accreditation and a New System Ethos, 43 VILL. L. REV. 361, 396-97 (1998). For example, the monitoring costs that would be borne by HCFA could be passed on to the Medicare HMO because they would pay a fee to the accrediting body, resulting in less costs to the government.

191. Id. at 397; see also Kinney, supra note 189, at 72 ("Private accreditors, independent of a regulatory role in government public health insurance programs, would have greater flexibility to conceptualize quality of care in innovative ways and possibly develop better quality standards for the health care institutions they accredit. In so doing, they would have great potential to promote pluralism, diversity, and competition among health care institutions and thus greater consumer choice in a changing health care environment."). In contrast to applying a regulatory scheme that requires all HMOs to meet the regulations by similar means, private accrediting bodies can allow HMOs to meet the same outcomes by various means, resulting in more flexible regulations.

192. See Furrow, supra note 190, at 397 (noting that self-enforcement is more readily accepted by the regulated entities).

193. See Clark C. Havighurst, Foreword: The Place of Private Accrediting Among the Instruments of Government, LAW. & CONTEMP. PROBS., Autumn 1994, at 1, 5 (1994) ("[Voluntary private accreditation] can be highly valued as a response to the information deficits that inevitably plague consumers shopping for complex goods or services.").

194. See Furrow, supra note 190, at 397. "The actual operation of private accreditation . . . is more responsive and more complex than simple government regulation would be." Id. at 399.
Private accreditation raises legitimate concerns. First, some observers question whether accrediting bodies can remain independent in the face of their reliance on accreditation fees paid by HMOs. Second, the accreditation process may be ineffective if the health care body being accredited can predict which parts of the operation will be reviewed by the accrediting body and thus only complies in those areas. Third, the accrediting bodies likely would be limited in their ability to investigate complaints because they would not carry the power of legal sanction. Fourth, the accrediting bodies would not be publicly accountable. Finally, arguments have been made that accreditation sometimes results in certification decisions that do not assure quality.

Some of these concerns, including those regarding the regularity of inspection and the failure to achieve quality, can be levied at the current public authorities that regulate health care. Even though the private accrediting bodies would receive fees, their long-term ability to receive the fees and the ability to certify the grievance and appeal process of HMOs would be dependent on maintaining government support. The most serious concern is that private accrediting bodies may not have the same ability to investigate complaints. In that case, the organizations must seek to deter improper HMO behavior, either by threatening to sanction HMOs by releasing negative information, or by revoking an HMO's certification, even if only done temporarily.

Despite these concerns, the payors of health care services, such as corporations, often use private accreditation to judge HMOs. For example, health insurers and those employers offering benefit plans look to accreditation organizations to ensure that they are purchasing high quality services and that the covered services are actually provided to enrollees. Similarly, Congress has viewed private accreditation as a way to guarantee quality for Medicare services; for example, Congress wanted to begin the Medicare program for hospital care quickly and utilized a private organization to

195. See id. at 397.
196. See id. at 397-98.
197. See id. at 398. Unlike the government which can wield legal sanctions, private accreditation lacks the same enforcement tools. The private accrediting body, however, can withhold the accreditation label which could jeopardize the health care provider's business and force them to be subjected to HCFA regulation.
198. See id. at 398-99; see also Kinney, supra note 189, at 71 (pointing out that the Joint Commission on Accreditation of Healthcare Organizations, the predominant private accreditation entity for allopathic health care organizations, has not been a quality standard development leader).
199. See infra note 214 and accompanying text.
200. See Kinney, supra note 189, at 55.
accredit hospitals. Despite the weaknesses identified above, voluntary private accreditation provides the clearest information to consumers and best seeks to improve the quality of the organizations it accredits.

2. Organizations with the Potential to Accredit HMOs—Private accrediting bodies certify that HMOs meet quality standards as defined by the bodies. Accreditation is not required by government agencies, but some private organizations require their health plans to be certified by specific agencies. Accreditation is voluntary because the HMO chooses to submit to the review and investigation of the accrediting body. There are five major private accrediting bodies that play a role in the accreditation of standards for the managed care industry. The National Committee for Quality Assurance (NCQA), which accredits managed care organizations, and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), which accredits hospitals and other health care providers, are the most nationally prominent accreditors in the area of managed care. These two bodies "are concerned about consumer protection issues and require [HMOs] to specify patient rights and responsibilities." JCAHO has been the predominant accrediting body since the 1950s. JCAHO initially accredited only hospitals, but now also accredits psychiatric and rehabilitation facilities and home health agencies. With JCAHO accreditation, a hospital "shall be deemed to meet" the Medicare requirements. JCAHO accredits, inspects, and issues warnings as to quality concerns and can hear informal appeals from hospitals stemming from a denial of accreditation or findings of deficiencies. JCAHO has an advantage over the gov-

201. See Judith M. Feder, Medicare: The Politics of Federal Hospital Insurance 7–32 (1997) (stating that the JCAHO was important in the decision to pass Medicare because it could assemble the resources quickly to assure quality among the nation’s hospitals); Kinney, supra note 189, at 55.

202. See Furrow, supra note 190, at 396–99. Other organizations that accredit HMOs are: the Accreditation Association for Ambulatory Health Care (AAAHC), which focuses on ambulatory care delivery entities; the Utilization Review Accreditation Commission (URAC); and The Medical Quality Commission (TMQC), which primarily surveys medical groups in California and individual practice associations that provide care in a capitated or prepaid setting.


205. See Kinney, supra note 189, at 52.

206. See id. at 54.


government because it is not subject to the federal rulemaking process and can issue new rules each year. However, there has been a significant amount of commentary on JCAHO, and some have argued that JCAHO should be more vigorous in investigating deficient quality of hospitals. JCAHO, as well as other private accrediting bodies, must balance the concerns of both the buyers and the sellers of health care, resulting in better efforts to judge quality.

NCQA began accrediting managed care organizations, among them HMOs, in 1991. NCQA's Board includes corporate representation, such as General Electric Corp., General Motors Corp. as well as other diverse interests including the AARP, Kaiser Foundation Health Plan, Inc., Aetna US Healthcare, and the United Food and Commercial Workers International Union. The board's composition shows that it is not dominated by managed care interests. Many companies, including UPS, Procter & Gamble, GE, Ameritech, Ford, and IBM request or require NCQA accreditation for their employees' health plans.

NCQA accreditation appears to be valued by so many businesses because of its sensitivity to factors that payors and users of HMOs find important. A substantial part of NCQA's HMO rating depends upon customer service. Illustrating how private accreditation can be sensitive to consumer needs, an HMO with deficient treatment of enrollees and a non-functioning grievance and appeal process will find NCQA accreditation more difficult to obtain. For example, one of NCQA's accrediting categories is "Access and Service." This category asks: "Do health plan members have access to the care and service they need? Do patients report problems getting needed care? How well does the health plan...

210. See, e.g., id.; see also Jost, supra note 204, at 880-83.
211. See Jost, supra note 209, at 45.
212. See id. (arguing that the JCAHO "may also become responsive to the consumer or employer alliances that will direct the purchase of health care. Because it must respond to these various interests, the Joint Commission is arguably better able to assure the quality of health care than would be any simple self-regulatory body").
215. See Furrow, supra note 190, at 401 n.211.
216. See id.
217. See id.
follow up on grievances?" This category constitutes 40% of a health plan's overall score. The other NCQA categories include "Qualified Providers" (20%), "Staying Healthy" (15%), "Getting Better" (10%), and "Living with Illness" (15%). Through a contract with HCFA, NCQA is conducting the Health Plan Employer and Data Information Set® (HEDIS®) Health of Seniors Survey (HOS) to study how health plans improve or maintain the functioning of Medicare beneficiaries. One of the strengths of this approach to accreditation is the focus on the perspective of the enrollee as a major part of the accreditation process. These questions and priorities address the goals outlined in Part IV.A. For example, they attempt to create a system that responds quickly to consumers and maintains the continuity of care provided to consumers. NCQA is a rigorous inspector. Only 40% of plans receive a three year accreditation, 35% receive a one year approval, 8% are accredited provisionally, and 11% are denied. If private accreditation was permitted as a way for HMOs to meet the HCFA standards, the criteria would likely need to be altered slightly to address the particular needs of Medicare HMO enrollees, but the focus on the needs of enrollees is an important factor in increasing the power of enrollees and designing the system to address their interests.

In addition to organizations that have existing accreditation programs for Medicare HMOs, there are many others that could develop more expansive programs. Some, such as MBDF, have volunteered to become Medicare HMO ombudsmen. Others, such as AARP, have significant resources, or funding for other consumer initiatives, to develop a consumer-oriented accreditation process. Currently, AARP certifies particular health plans for its

218. Id.
220. See id.
222. See Furrow, supra note 190, at 401.
224. See supra note 182 and accompanying text.
225. See generally AARP Weblpace (visited Mar. 14, 2000) <http://www.aarp.org/indexes/member.htm> (on file with the University of Michigan Journal of Law Reform) (giving information on member benefits). The AARP claims over thirty million Americans as members, publishes one of the most widely read magazines, and has significant revenues from several activities, such as advertising, that permit it to develop innovative consumer-oriented programs. See generally AARP, 1998 Annual Report (visited Mar. 14, 2000) <http://
extensive membership. In short, several private organizations exist that could competently serve as government-certified private accreditation bodies for the grievance and appeal process of Medicare HMOs. Numerous private organizations have experience in this area and could create a framework for accrediting Medicare HMOs and monitoring their ability to meet standards that seek to address the concerns of Medicare enrollees.

V. CONGRESS SHOULD PASS LEGISLATION PERMITTING VOLUNTARY PRIVATE ACCREDITATION OF MEDICARE HMOs FOR THE GRIEVANCE AND APPEAL PROCESS TO MEET FEDERAL REQUIREMENTS

Private accreditation can be applied to other aspects of managed care organizations, or even all managed care operations, but this Note limits its discussion to how private accreditation will benefit consumers by providing a better grievance and appeal structure. Based on the current inadequate level of HCFA oversight and the unrealized potential of private accreditation bodies, Congress and HCFA should allow Medicare HMOs to seek private accreditation in lieu of HCFA regulation and approval for the grievance and appeal process. This proposal would permit HCFA to certify private agencies to accredit this aspect of managed care organizations.

This procedure would be similar to that currently followed by hospitals: a hospital may choose either to be accredited and reviewed by the JCAHO or to be evaluated under the HCFA standards. Applied to HMOs, this proposal would not foreclose HCFA oversight; managed care organizations and their grievance and appeals processes would still be subject to the oversight of HCFA, but HMOs could be certified to receive Medicare payments by choosing to be privately accredited by a federally approved organization.

Adopting a voluntary private accreditation process would have two positive effects. First, allowing private accreditation bodies to determine whether Medicare HMOs meet the Medicare Act’s and regulations’ requirements for grievance and appeal processes would provide consumers with signals as to how they will be treated


if the HMO renders an adverse organization determination. For example, the Continuing Care Accreditation Commission (CCAC), although not focused on managed care entity, accredits Continuing Care Retirement Communities (CCRCs) that serve various health care needs of older Americans. An evaluator of the CCAC explained that it has “the potential to improve significantly the information available to consumers.... [A] consumer's choice between two otherwise apparently comparable CCRCs should be made significantly easier if one carries the industry's seal of approval and the other does not.” In practice, this accreditation gives cues to consumers that, if applied to HMOs, could assist Medicare enrollees in deciding which HMO to join.

Accreditation, therefore, would inform consumers about the operations of the plan's grievance and appeal process and assist the elderly in understanding how various HMOs differ in quality. Especially for the poor and disabled elderly, who have been shown to know the least about managed care, accreditation can make their choices easier by increasing available information and decreasing search costs of researching individual HMOs. Optional private accreditation will encourage HMOs to compete for enrollees by seeking accreditation labels and this competition will result in better service for Medicare HMO enrollees. Higher-quality HMOs will earn labels that will illustrate that they have met the presumably high standard of the private accrediting bodies. Inferior HMOs will avoid the process and lose business because they will not be able to attain the accreditation.

More HMOs will seek this regulation for the “reputation” effect of ensuring quality and consumer friendliness to their grievance and appeal rights, but, additionally, it will result in more flexible regulatory standards. The private accrediting bodies can regulate through more outcome-based regulations that may result in more creative solutions to meet the needs of consumers than under HCFA currently. Since the process is voluntary, HMOs will likely seek private accreditation since it may be more constructive in addressing the legal requirements of Medicare HMOs' grievance and

227. The CCAC was developed by the American Association of Homes and Services for the Aging (AAHSA), the largest organization of non-profit health care providers devoted to providing services to the elderly. One of the goals in developing CCAC was to develop high quality standards for CCRCs that may not be realized under standard regulatory techniques. See Paul A. Gordon, J.D., Developing Retirement Communities, Volume I: Business, Tax and Regulatory Issues 432 (2d ed. 1993).


229. See supra notes 71-73 and accompanying text.
appeals processes than the procedure under HCFA. Once private accreditators are allowed to certify the grievance and appeal process, those Medicare HMOs that can meet the higher standards will likely choose private accreditation.

As a result, more Medicare HMOs will be driven, through competition for the accreditation labels, to comply with federal regulations. This will permit HCFA, currently burdened by the present caseload, to focus its efforts on those HMOs that do not meet the more consumer-oriented standards, hopefully reducing the number of HMOs that currently do not meet federal law and threaten the health and rights of Medicare HMO enrollees. Thus, a byproduct of this proposal is that it will increase the effectiveness of HCFA.

Second, some accrediting groups could impose additional requirements that are targeted specifically to the elderly, or become advocates for elderly patients. Accrediting groups could also serve as a complaint center and mediate disputes between an enrollee and her HMO. Furthermore, the accreditation groups will be more familiar with the best way to phrase notices and administer a program that is most compatible with the different needs of elderly consumers. This will result in a more flexible and creative regulatory approach.

Many payors of health care have not perceived HCFA regulation and compliance as providing adequate assurances of quality when it comes to choosing which health plans they should offer their employees. Instead, these employers and health insurance companies are developing and relying upon private accreditation systems. As stated by the GAO, HCFA's lack of enforcement has not had a greater negative impact largely because private accreditation efforts have developed quickly. The growth of accreditation in the private sector is due to private groups' focus on different criteria than the federal government, specifically those criteria favored by corporate payors such as high quality service for users and value for their money. The U.S. government, as a major payor of Medicare expenses, should follow the private sector and insist on higher standards for its beneficiaries.

Private accreditation is not a substitute for all government regulation. This Note does not argue that HCFA should scale back any

230. See Rodwin, supra note 10, at 1354–55. For example, the MBDF proposed serving in this role. See id.

231. See supra Part IV.C.

232. See U.S. GENERAL ACCOUNTING OFFICE, supra note 15; see also supra text accompanying note 155.
statutes or regulations. Current regulations and HCFA enforcement must remain in place because private accreditation is only an alternative to standard government regulation. Because the federal government is the single largest payor of health care services and HCFA plays a large role in implementing the Medicare program, HCFA should remain as an alternative to accredit and monitor HMOs. Indeed, an HMO might seek certification from multiple bodies, signaling to consumers that the HMO will meet the requirements of any accrediting body because of its higher standards in the area of grievance and appeal.

CONCLUSION

This Note suggests a way to strengthen the Medicare HMO grievance and appeal process in order to empower consumers. Because Congress is anxious to move more Medicare beneficiaries into HMOs, it should take a cue from a previous Congress that incorporated private accreditation for hospitals when great numbers of Medicare beneficiaries entered the private hospital system. This Note does not recommend a specific organization to assume the role of accrediting the grievance and appeal process for Medicare HMOs. The decision as to which groups to use and the requirements of what expertise and resources those groups should have in developing consumer-oriented programs of accreditation should be left to Congress. Current HCFA regulation has not improved the condition of Medicare enrollees. To provide better consumer information and increased compliance, Congress should create a permissive private accreditation system for the internal grievance and appeal programs of Medicare HMOs. Allowing Medicare HMOs to meet the goals of regulations through alternative means will serve to address the concerns of Medicare enrollees and provide a more responsive grievance and appeal process.

233. See FEDER, supra note 201, at 7–32 and accompanying text.