*** § 4408-a. Grievance procedure.** 1. A health maintenance organization licensed pursuant to article forty-three of the insurance law or certified pursuant to this article, and any other organization certified pursuant to this article shall establish and maintain a grievance procedure. Pursuant to such procedure, enrollees shall be entitled to seek a review of determinations by the organization other than determinations subject to the provisions of article forty-nine of this chapter.

2. (a) An organization shall provide to all enrollees written notice of the grievance procedure in the member handbook and at any time that the organization denies access to a referral or determines that a requested benefit is not covered pursuant to the terms of the contract; provided, however, that nothing herein shall be deemed to require a health care provider to provide such notice. In the event that an organization denies a service as an adverse determination as defined in article forty-nine of this chapter, the organization shall inform the enrollee or the enrollee's designee of the appeal rights provided for in article forty-nine of this chapter.

(b) The notice to an enrollee describing the grievance process shall explain: (i) the process for filing a grievance with the organization; (ii) the timeframes within which a grievance determination must be made; (iii) the right of an enrollee to designate a representative to file a grievance on behalf of the enrollee; and (iv) notice of the name, address, phone number and website of the department designated consumer assistance program and the independent substance use disorder and mental health ombudsman established by section 33.27 of the mental hygiene law within notices of adverse grievances and appeals determinations.

(c) The organization shall assure that the grievance procedure is reasonably accessible to those who do not speak English.

3. (a) The organization may require an enrollee to file a grievance in writing, by letter or by a grievance form which shall be made available by the organization and which shall conform to applicable standards for readability.

(b) Notwithstanding the provisions of paragraph (a) of this subdivision, an enrollee may submit an oral grievance in connection

with: (i) a denial of, or failure to pay for, a referral; or (ii) a determination as to whether a benefit is covered pursuant to the terms of the enrollee's contract. In connection with the submission of an oral grievance, an organization may require that the enrollee sign a written acknowledgment of the grievance prepared by the organization summarizing the nature of the grievance. Such acknowledgment shall be mailed promptly to the enrollee, who shall sign and return the acknowledgment, with any amendments, in order to initiate the grievance. The grievance acknowledgment shall prominently state that the enrollee must sign and return the acknowledgment to initiate the grievance. If an organization does not require such a signed acknowledgment, an oral grievance shall be initiated at the time of the telephone call.

(c) Upon receipt of a grievance, the organization shall provide notice specifying what information must be provided to the organization in order to render a decision on the grievance.

(d) (1) An organization shall designate personnel to accept the filing of an enrollee's grievance by toll-free telephone no less than forty hours per week during normal business hours and, shall have a telephone system available to take calls during other than normal business hours and shall respond to all such calls no less than the next business day after the call was recorded.

(2) Notwithstanding the provisions of subparagraph one of this paragraph, an organization may, in the alternative, designate personnel to accept the filing of an enrollee's grievance by toll-free telephone not less than forty hours per week during normal business hours and, in the case of grievances subject to subparagraph (i) of subdivision four of this section, on a twenty-four hour a day, seven day a week basis.

4. Within fifteen business days of receipt of the grievance, the organization shall provide written acknowledgment of the grievance, including the name, address and telephone number of the individual or department designated by the organization to respond to the grievance. All grievances shall be resolved in an expeditious manner, and in any event, no more than: (i) forty-eight hours after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health; (ii) thirty days after the receipt of all necessary information in the case of requests for referrals or

determinations concerning whether a requested benefit is covered pursuant to the contract; and (iii) forty-five days after the receipt of all necessary information in all other instances.

5. The organization shall designate one or more qualified personnel to review the grievance; provided further, that when the grievance pertains to clinical matters, the personnel shall include, but not be limited to, one or more licensed, certified or registered health care professionals.

6. The notice of a determination of the grievance shall be made in writing to the enrollee or to the enrollee's designee. In the case of a determination made in conformance with subparagraph (i) of subdivision four of this section, notice shall be made by telephone directly to the enrollee with written notice to follow within three business days.

7. The notice of a determination shall include: (i) the detailed reasons for the determination; (ii) in cases where the determination has a clinical basis, the clinical rationale for the determination; (iii) the procedures for the filing of an appeal of the determination, including a form for the filing of such an appeal; and (iv) notice of the name, address, phone number and website of the department designated consumer assistance program and the independent substance use disorder and mental health ombudsman established by section 33.27 of the mental hygiene law within notices of adverse grievances and appeals determinations.

8. An enrollee or an enrollee's designee shall have not less than sixty business days after receipt of notice of the grievance determination to file a written appeal, which may be submitted by letter or by a form supplied by the organization.

9. Within fifteen business days of receipt of the appeal, the organization shall provide written acknowledgment of the appeal, including the name, address and telephone number of the individual designated by the organization to respond to the appeal and what additional information, if any, must be provided in order for the organization to render a decision.

10. The determination of an appeal on a clinical matter must be made by personnel qualified to review the appeal, including licensed, certified or registered health care professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer as defined in article forty-nine of this chapter. The determination of an appeal on a matter which is not clinical shall be made by qualified personnel at a higher level than the personnel who made the grievance determination.

11. The organization shall seek to resolve all appeals in the most expeditious manner and shall make a determination and provide notice no more than:

(i) two business days after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health; and

(ii) thirty business days after the receipt of all necessary information in all other instances.

12. The notice of a determination on an appeal shall include: (i) the detailed reasons for the determination; and (ii) in cases where the determination has a clinical basis, the clinical rationale for the determination.

13. An organization shall not retaliate or take any discriminatory action against an enrollee because an enrollee has filed a grievance or appeal.

14. An organization shall maintain a file on each grievance and associated appeal, if any, that shall include the date the grievance was filed; a copy of the grievance, if any; the date of receipt of and a copy of the enrollee's acknowledgment of the grievance, if any; the determination made by the organization including the date of the determination and the titles and, in the case of a clinical determination, the credentials of the organization's personnel who reviewed the grievance. If an enrollee files an appeal of the grievance, the file shall include the date and a copy of the enrollee's appeal, the

determination made by the organization including the date of the determination and the titles and, in the case of clinical determinations, the credentials, of the organization's personnel who reviewed the appeal.

15. An organization shall have procedures for obtaining an enrollee's, or enrollee's designee's, preference for receiving notifications, which shall be in accordance with applicable federal law and with guidance developed by the commissioner. Written and telephone notification to an enrollee or the enrollee's designee under this section may be provided by electronic means where the enrollee or the enrollee's designee has informed the organization in advance of a preference to receive such notification by electronic means. An organization shall permit the enrollee and the enrollee's designee to change the preference at any time. The organization shall retain documentation of preferred notification methods and present such records to the commissioner upon request.

16. The rights and remedies conferred in this article upon enrollees shall be cumulative and in addition to and not in lieu of any other rights or remedies available under law.

* NB There are 2 § 4408-a's