**Section 4521.40 Grievance Procedure**

a) Every HMO shall submit for the Director's approval, and maintain, a system for the resolution of grievances concerning the provision of health care services or other matters concerning operation of the HMO as follows. Each HMO shall:

1) Submit to the Director for prior approval any proposed changes to the system by which grievances may be filed and reviewed;

2) Maintain records of each grievance, filed with the HMO until the grievance is resolved and for a period of at least 3 years, that includes:

A) A copy of the grievance, the date of its filing;

B) The date and outcome of all consultations, hearings and hearing findings;

C) The date and decisions of any appeal proceedings; and

D) The date and proceedings of any litigation;

3) Submit to the Director, in a form prescribed by the Director, a report by March 1 for the previous calendar year that includes at least the following:

A) the total number of grievances handled;

B) a compilation of causes underlying the grievances;

C) the outcomes of the grievances;

D) the elapsed time from receipt of the grievance by the HMO until its conclusion; and

E) the number of malpractice claims filed and, if those claims have been completely adjudicated, a compilation of causes, disposition, form and amount of any settlements.

b) Every HMO shall have a grievance committee with the authority to hear and resolve by majority vote grievances submitted to it as provided in subsection (a).

1) Notwithstanding any other provisions of this Section, the grievance committee may, but is not required to, hear any grievance that alleges or indicates possible professional liability, commonly known as "malpractice".

2) The committee is not empowered to resolve grievances in any manner, or prescribe any actions, that are in conflict with written policies of the HMO's Governing Body, but the committee may hear such grievances for the purpose of providing input to the Governing Body.

3) The grievance committee shall meet at the main office of the HMO, or other office designated by the HMO if the main office is not within 50 miles of the grievant's home address. Consideration shall be given to the enrollee's request pertaining to the time and date of the meeting. The enrollee shall have the right to attend and participate in the formal grievance proceedings. The enrollee shall have the right to be represented by a designated representative of his or her choice.

4) The filing of a grievance shall not preclude the enrollee from filing a complaint with the Department, nor shall it preclude the Department from investigating a complaint pursuant to its authority under Section 4-6 of the Act.

c) The grievance procedures must be fully and clearly communicated to all enrollees and information concerning grievance procedures shall be readily available to the enrollee.

d) Every HMO shall have simplified procedures for resolving complaints. The procedures do not require review of the complaint by the grievance committee, but a log, file, or other similar records must be maintained to identify the general nature of the complaints. Resolution of complaints shall not preclude the enrollees' rightful access to review by the grievance committee of a grievance.

e) The HMO shall institute procedures that would require grievances to have a determination made by the grievance committee within 60 days from the date the grievance is received by the HMO. A grievance may not be heard or voted upon unless at least 50% of the voting individuals of the committee are enrollees. The determination by the grievance committee may be extended for a period not to exceed 30 days in the event of a delay in obtaining the documents or records necessary for the resolution of the grievance. All requests for documents or records necessary for the resolution of the grievance shall be maintained in the HMO's grievance file.

f) The grievance procedure shall provide the enrollee with a written acknowledgment of the grievance within 10 business days after receipt by the HMO.

g) The enrollee shall be notified at the time of the hearing of the name and affiliation of those grievance committee members who are representatives of the HMO.

h) The HMO shall institute procedures whereby any documentation furnished to the members of the grievance committee shall also be made available to the enrollee not less than 5 business days prior to the hearing of the grievance. The HMO shall not present any evidence without the enrollee having been given the opportunity to be present.

i) Notification in writing of the determination of the grievance committee shall be mailed to the enrollee within 5 business days after the determination. Notice of the determination made at the final appeal step of the HMO's grievance process shall include a Notice of Availability of the Department that the HMO shall send to its enrollees explaining that the Department is available to respond to their inquiries.

j) Prior to the resolution of a grievance filed by a subscriber or enrollee, coverage shall not be terminated for any reason that is the subject of the written grievance, except when the HMO has, in good faith, made a reasonable effort to resolve the written grievance through its grievance procedure and coverage is being terminated as provided for in Section 4521.111 of this Part.

(Source: Amended at 37 Ill. Reg. 14032, effective August 26, 2013)