POLICY PURPOSE
To have a process to properly investigate, respond to, track and trend quality of care member complaints and grievances.

SCOPE
This policy applies to the entire Medicare Advantage Part C population.

REFERENCES
Part C & D, Member Grievances, Organization/Coverage Determinations and Appeals Guidance: 30.3-30.4 - Quality of Care Grievances

- Part C 42 CFR §§422.564 (e)(1) and (2)
- Part D §423.564(e)(2)

RESPONSIBLE PARTIES
- Senior Director of Quality

DEFINITIONS
Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO): Organizations composed of practicing doctors and other health care experts under contract to the federal government to monitor and improve care given to Medicare members. The BFCC-QIOs review member complaints about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities (SNFs), home health agencies (HHAs), Medicare managed care plans,
Medicare Part D prescription drug plans, and ambulatory surgical centers. The BFCC-QIOs also review continued stay denials in acute inpatient facilities as well as coverage terminations in SNFs, HHAs, and comprehensive outpatient rehabilitation facilities (CORFs). In some cases, the BFCC-QIO can provide informal dispute resolution between the health care provider (e.g., physician, hospital, etc.) and member.

**Complaint:** Any expression of dissatisfaction to a plan, provider, facility or Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO) by a member made verbally or in writing. Under Part D, a complaint may also involve a late enrollment penalty (LEP) determination.

**Grievance:** An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or an LEP determination.

**Representative:** Under Part C, as defined in §422.561, an individual appointed by a member or other party, or authorized under state or other applicable law, to act on behalf of a member in filing a grievance, organization determination, or appeal. Under Part D, as defined in §423.560 as “appointed representative”, an individual either appointed by the member or authorized under state or other applicable law to act on behalf of the member in filing a grievance, obtaining coverage determination, or in dealing with any of the levels of the appeals process. For both Part C & Part D, the representative will have all the rights and responsibilities of the member or other party, as applicable.

**Quality of Care Grievance:** A quality of care grievance is a type of grievance that is related to whether the quality of covered services provided by a plan or provider meets professionally recognized standards of health care, including whether appropriate health care services have been provided or have been provided in appropriate settings.

Examples of a quality of care grievance include any instances where a member infers or states they believe:

- They were misdiagnosed;
- Treatment was not appropriate; and/or
- They received, or did not receive, care that adversely impacted or had the potential to adversely impact their health.

**POLICY**

Troy Medicare has established and maintains a grievance/complaint procedure to address quality of care grievances and complaints in a timely manner that do not involve organizational determinations.

- A member may file a quality of care complaint to Troy Medicare either orally or in writing.
- Quality of care grievances/complaints are submitted by members or the members’ representatives about quality of services received from practitioners or providers such as hospitals.

**Timeframes**
A member or their authorized representative must file a grievance or complaint no later than 60 days after the event or incident that precipitates the grievance/complaint.

Untimely Filing

- Troy Medicare may, but is not required to, accept and process a quality of care grievance received after the 60-day deadline.
- If Troy Medicare chooses not to accept an untimely filing, the quality of care grievance may be dismissed.

Evaluation, Investigation, Tracking & Resolution

- Member quality of care grievances/complaints received orally or in writing in relation to the quality of services received from a practitioner or provider, need to be thoroughly investigated, evaluated and tracked for purposes of possible sanction, and resolved/responded to in writing within 30 days of receipt, or as expeditiously as the member’s health condition requires.
- Troy Medicare will use the minimal necessary information to investigate and evaluate the complaint.

14-Day Time Frame Extension for QOC Grievance/Complaint Resolution

- Troy Medicare may extend the 30-day timeframe by up to 14 days (totaling 44 days) if the member requests the extension or Troy Medicare justifies a need for additional information and documents how the delay is in the interest of the member.
- When Troy Medicare extends a deadline, it must immediately notify the member about the reasons for the delay in writing.

Troy Medicare Response to Member

- All complaints/grievances related to quality of care, regardless of how the grievance is filed must be responded to in writing.
- The response must include a description of the member’s right to file a written complaint with the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO).
- For any complaint submitted to a BFCC-QIO, Troy Medicare must cooperate with the BFCC-QIO in resolving the complaint.

Recordkeeping

Troy Medicare must have an established process to track and maintain records on all complaints/grievances received both orally and in writing, including at a minimum, the date of receipt, final disposition of the complaint/grievance, and the date that Troy Medicare notified the member of the disposition.

Part D Quality of Care Complaints/Grievances

Part D quality of care complaints are handled by Troy Medicare’s Pharmacy Benefits Manager (PBM).

PROCEDURE
Authorization of Representative

A member has the right to designate an authorized legal representative to act on their behalf at any time during the quality of care complaint/grievance process. The designated representative may include a healthcare provider or attorney. After reviewing the quality of care complaint/grievance, the QI Coordinator determines if someone other than the member is filing the complaint/grievance on the member’s behalf. If so, the QI Coordinator takes the following steps:

1. The QI Coordinator will first check the care management system to determine if Troy Medicare has valid representative documentation on file. Valid documentation includes an Appointment of Representative (AOR) form, written equivalent, or other legal documentation that demonstrates representation per State law (e.g., guardianship papers, health care proxy, someone who is documented as a Durable Power of Attorney, etc).
   a. For AOR documentation to be valid, it must be signed and dated by both the member and the representative and must have been signed within one (1) year of the receipt date of the current grievance/complaint.

2. If there is not valid representative documentation on file, the QI Coordinator communicates information to the member and the representative (separately, if the representative provides an address to communicate) in writing the need for a signed Appointment of Representative (AOR) form, and includes an AOR form for completion, with clear instructions of what’s needed to have a fully executed authorization. This is documented in the QOC Investigation Tracker and retained in the restricted QOC Investigation folder. The letter also explains to the member that Troy Medicare cannot process the grievance/complaint until the AOR or other valid representative documentation is received.
   a. The grievance is left open for the duration of its life cycle based on CMS timeframes.
   b. If an AOR or equivalent is received, case research begins, and the timeframe begins based on the date/time of the receipt of the completed documentation.
   c. If the documentation is not received, the case is dismissed, and a dismissal letter is sent to the member and representative. The Dismissal letter will be linked in the QOC Investigation Tracker and retained in the restricted QOC Investigations folder and the case will be closed based on the date/time of the sent Dismissal letter.
Referrals

- Quality of care concerns can be referred by physician reviewers and/or health care professionals such as a Care Manager nurse. These Quality of Care concerns are first referred to the Grievance team who will review the concern as “founded” or “unfounded”.
  - Quality of Care concerns considered to be founded will be referred via email to QOC@troymedicare.com.

- Upon receipt of a QOC grievance/complaint in QOC@troymedicare.com email, the QI Coordinator will review the documentation received from the member (email referral notes for a verbal grievance; the member’s letter for a written grievance).

- Quality of Care grievances may be received and acted upon by Troy Medicare, the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), or both.
  - For any grievance submitted to the BFCC-QIO, Troy Medicare must cooperate with the BFF-QIO in resolving the grievance, including directing providers to respond to BFCC-QIO requests for information, within 14 days. Troy Medicare should provide any records and requested information as quickly as possible and within 14 days.

Documentation of QOC Complaint/Grievance

- For the entirety of the QOC complaint/grievance process, once a case is received to QOC@troymedicare.com, all information is entered by the QI Coordinator or the QI Clinical Nurse Reviewer in a secure, protected database for the purpose of tracking, trending and archival.

- Links to the member phone call recordings, letter correspondence, emails, faxed requests including time stamps will be archived in the restricted Quality Program QOC investigations folder and each document/call recording, etc, will be linked within the QOC investigations tracker.

Medical Record Request

- The QI Coordinator confirms the provider(s) who is(are) named in the QOC grievance and calls their office to obtain relevant medical records.

- The QI Coordinator will request medical records from providers/practitioners that relate to the member’s complaint or grievance within five (5) calendar days of receipt of the complaint/grievance. Additional medical records may be requested by the Clinical Nurse Reviewer.
  - If information is not received at Troy Medicare within 14 calendar days of the request the Quality team will contact the provider to clearly state the importance of the requested information.
  - If the QI Coordinator does not receive the requested information, he/she/they will make at least two more follow up attempts with the provider to ensure timely delivery of documentation.
    ■ The QI Coordinator will also work with Provider Relations efforts to retrieve the requested medical records.

- Upon receipt of the relevant medical records, the QQI Coordinator will do an initial review of the documentation to ensure completeness and will forward all case
documentation to the clinical Nurse reviewer for review and provisional/recommended severity assignment from a Level 0 to a Level 4, from lowest severity to highest.

- All medical record requests and receipts of information are tracked in the QOC Investigation Tracker and within the restricted Quality QOC investigations folder. Links to medical records will be embedded within the QOC investigation tracker.

Time frame Extensions

- If the Quality team needs more than 30 days to investigate and resolve a standard QOC complaint/grievance, and that additional time is in the member's best interest, and the QI Coordinator delivers the decision to extend no later than the 29th calendar day, including an explanation of the reason the extension is necessary and how it is in the best interest of the member.
- The amount of time by which the plan is extending the process cannot exceed 14 calendar days.

Medical Record Review

- If information is received, the Clinical Nurse reviewer conducts a review and evaluation of the issue and documents it within the QOC Investigation Tracker.
- If the information is not received, the Clinical Nurse Reviewer will note it in the QOC Investigation Tracker.
- All cases, regardless whether medical records were received or not, are brought to the VP of Medical Management and Senior Director of Quality once the review is completed by the Clinical Nurse Reviewer.
  - The Clinical Nurse Reviewer will place the case on agenda for weekly review with the VP of Medical Management and the Senior Director of Quality.

VP of Medical Management & Senior Director of Quality Review

- Once the medical record review is completed (with or without receipt of requested medical records), the case is forwarded to the VP of Medical Management and the Senior Director of Quality for presentation, final review and recommendations for next steps/interventions, as well as a Final Severity code assignment.
- The VP of Medical Management and the Senior Director of Quality will review the concern and evaluation prepared by the Clinical Nurse Reviewer as well as supporting documentation and will finalize the case severity score.

QOC Review: Outcomes and Interventions

- Once the VP of Medical Management and the Senior Director of Quality have reviewed the case, additional intervention steps may be taken per direction including but not limited to:
  - Referral to case management for coordination of needs, provider/specialist scheduling assistance, etc.
  - If the provisional severity score is 2a or higher, a letter signed by the Chief Medical Officer is sent to the provider with case resolution and further action plan. A copy of the letter is emailed to the Credentialing Manager to be included in the provider credentialing file.
If the provisional severity score is 2b or higher, the Chief Medical Officer will convene a Peer Group of at least three (3) peers. The peer group will review the grievance and all pertinent documentation and will render a final determination as per clinical severity level and further action. This is documented in the Provider credentialing file and the Credentialing department is notified of the outcome of the Peer Group review by the Chief Medical Officer.

- Any case designated as level 2b or above will be sent to the Credentialing Department for further action.
- A provider who receives a score of “3—three” will be presented to the next credentialing committee meeting by the Chief Medical Officer for evaluation and possible sanction or termination.
- A provider with three (3) or more complaints scored “1—one” in a six month period will be presented at the next credentialing committee meeting for evaluation and possible sanction.
- For QOC grievances designated as Level 0, Level 1, or Level 2a, the Clinical Nurse reviewer will ensure inclusion in the resolution letter conclusion of the investigation.
- If records are not received and/or severity score cannot be assessed, the resolution letter will include all the available information based on the case research, including our attempts to obtain the requested information, along with instructions on contacting the BFCC-QIO for further assistance.
- The Network team is notified of case outcomes for tracking/trending.

All documentation is retained in the QOC Investigation Tracker and the member folder located within the restricted QOC investigations folder.

Written Notice (Resolution Letter)

- The written notice must:
  - include a description of the member’s right to file a grievance with the BFCC-QIO;
  - and be written in a manner that is of easy understanding to the member; and
  - if the member’s representative submits a request, the representative must be notified in lieu of the member. Plans may send written notice to both the representative and member, but are not required.

Quality of Care Complaints Submitted to the BFCC-QIO

- In some instances, members may submit quality of care complaints directly and exclusively to the BFCC-QIO or they may do it at the same time they submit the concern to Troy Medicare.
- If the complaint is submitted to the BFCC-QIO only, it is the BFCC-QIO responsibility to conduct the investigation and provide the member with a case resolution. During the process of investigation, the BFCC-QIO may request the collaboration of Troy Medicare.
- If submitted to Troy Medicare and the BFCC-QIO, the investigation and resolution must be conducted in full collaboration. Troy Medicare will take the lead in the process.
For grievances submitted to the BFCC-QIO, Troy Medicare must cooperate with the BFCC-QIO and comply with the requirements at 42 CFR Part 476 regarding timely submission of requested information to the BFCC-QIO if a member files a grievance with the BFCC-QIO and the Troy Medicare.

Procedures for Handling Withdrawn Quality of Care Grievances/Complaints

If the member submits a quality of care grievance verbally or in writing, but later decides to withdraw the grievance, Troy Medicare is still required to investigate the quality of care grievance; however, Troy Medicare is not required to notify the member of the outcome of the grievance since they decided not to pursue it.

○ At any time during the grievance process before the decision is delivered, the member may submit a written withdrawal request for a grievance at any time before the decision is mailed by the plan.

○ Troy Medicare accepts verbal withdrawals for both written and verbal grievances/complaints received from a member any time before the decision is mailed by the plan. Once the withdrawal request is received, the following actions are taken:
  ■ The request for withdrawal will clearly be documented in the QOC Investigation Tracker case and documentation archived in the restricted QOC investigations folder for the member’s case.
  ■ The QI Coordinator will send written confirmation of that withdrawal to the member within three (3) calendar days of receiving the withdrawal request.
  ■ Any work on the case will continue; the investigation will continue internally after the withdrawal but the member/AOR will not be notified of the outcome.
  ■ The case will be closed based on the date and time of the withdrawal request, and documented in the QOC Investigation Tracker as withdrawn.

ATTACHMENTS/RELATED POLICIES/STANDARD OPERATING PROCEDURES

Related Policy A: A&G_101_Member Grievances

APPROVALS

[Signature]
Head of Quality
11 / 11 / 2022

Date: