HERITAGE PROVIDER NETWORK
&
AFFILIATED MEDICAL GROUPS

GRIEVANCE PROGRAM 2023

Approval Signature

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GRIEVANCE PROGRAM

PURPOSE

Heritage Provider Network (HPN) and its affiliated Medical Groups shall ensure that it supports the full-service Health Plans in processing grievances pursuant to NCQA, State, and Federal requirements and that it performs the appropriate tracking, consideration and resolution (when appropriate) of grievances given its non-delegated status.

OUR ROLE

HPN and its Medical Groups are not delegated by any full-service Health Plan to process or resolve member grievances or member complaints. However, we shall forward any complaints received to the Health Plan for processing, per our agreements and non-delegated status. We shall also conduct an internal investigation of all complaints received to better improve the quality of the services rendered to our members.

The Medical Group must also have written information available to the member or their representative about how to file a complaint with their respective Health Plan. This information will be provided in the member handbook distributed by contracted health plans and includes but is not limited to:

1. The right to file a grievance
2. The requirements and time frames for filing a grievance
3. The availability of assistance in the grievance filing process

HPN has an online form through its internet web site that subscribers or enrollees can use to file a grievance. These forms are located at: www.heritageprovidernetwork.com - under the Member's tab, Grievance Form.

POLICY

Each Medical Group shall establish and adopt the HPN Grievance Program. Staff training shall be conducted upon hire, and annually thereafter to ensure the Group complies with the program and established regulatory guidelines.

1. HPN and the Medical Groups will not discriminate against any member solely on the grounds that the member filed a complaint, (including disenrollment or cancellation of contract), and we shall ensure that all member information is kept strictly confidential.

2. HPN and the Medical Groups shall ensure that the linguistic and cultural needs of its member population and of those with disabilities are met. Our grievance system will ensure that all members have access to and can fully participate in the grievance process by providing assistance for those with limited English proficiency, or with a visual or other communicative impairment.

3. HPN and the Medical Groups will ensure that member health records are available and accessible

to authorized staff of their organization and to appropriate State and Federal authorities or their delegates involved in assessing quality of care or investigating member or provider quality of care concerns, complaints, and allegations of abuse, neglect, and exploitation. Member record availability and accessibility must be in compliance with Federal and State confidentiality laws, including, but not limited to, Health Insurance Portability and Accountability Act (HIPAA) and 42 C.F.R. 431.300 et seq.

4. Copies of complaints and responses shall be maintained for no less than five years, and shall include a copy of all medical records, documents, and other relevant information. All information shall be made available to the member, provider, Health Plan, State, and/or Federal authorized representative upon request.

DEFINITIONS

Complaint
A complaint is the same as a Grievance.

Complainant
"Complainant" is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.

Grievance
A Grievance is an expression of dissatisfaction about any matter other than an *Adverse Benefit Determination*. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by the Health Plan to make an authorization decision.

While the state definition does not specifically distinguish "Grievances" from "Appeals," federal regulations define "Grievance" and "Appeal" separately.[1] *Due to distinct processes delineated for the handling of each, Health Plans shall adopt the federal definition but also incorporate applicable sections of the existing state definition that do not pose conflicts.*

Inquiry
An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other Health Plan processes.

Pending Grievance
Grievances that are not resolved within 30 calendar days, or grievances referred to the Department's complaint or independent medical review system, shall be reported as "pending" grievances. Grievances referred to external review processes, such as reviews of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, or the Medi-Cal Fair Hearing process, shall also be reported as pending until the

[1] Title 42, CFR, Section 438.400(b)

review and any required action by the plan resulting from the review is completed.

Resolved
"Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority.

Disputed Health Care Service
Any health care service eligible for coverage and payment under a health care service plan contract that has been denied, modified, or delayed by a decision of the plan, or by one of its contracting providers, in whole or in part due to a finding that the service is not medically necessary. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision.
A disputed health care service does not include services provided by a specialized health care service plan, except to the extent that the service
(1) involves the practice of medicine, or
(2) is provided pursuant to a contract with a health care service plan that covers hospital, medical, or surgical benefits.

Coverage Decision
Is the approval or denial of health care services by a plan, or by one of its contracting entities, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the health care service plan contract. A "coverage decision" does not encompass a plan or contracting provider decision regarding a disputed health care service.

STAFF RESPONSIBILITY

Designated Physician

The Quality Medical Director or designated physician will review each complaint received and make recommendations based on various analyzed clinical care and administrative data and may refer cases to the Quality Review Committee for more intensive review. Documented evidence of the Medical Director's review shall be maintained in each case file.

1. He/she must be a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the complaint by the member.
2. The designated physician must determine that he or she is competent to evaluate the specific clinical issues presented. If the designated physician determines that he/she is not competent to evaluate the specific clinical issues of the complaint, he/she shall consult with an appropriately licensed health care provider who is competent to evaluate the specific clinical issues presented. The reviewer must have the education, training, and relevant expertise that are pertinent for evaluating the specific clinical issues that serve as the basis of the complaint.
3. If there is a conflict of interest, the Medical Director or his/her designee involved in the review process must remove themselves from the case. No persons shall be involved in the review process of Quality Improvement issues in which they were directly involved. Another qualified reviewer must be assigned.

4. The Medical Director or his/her designee must state their rationale for making their determination, and refer back to the specific clinical practice guideline, provision in the contract, criteria, or member handbook that for which their determination was based. It must be in clear and concise language that explains how it applied to the specific health care service, or quality of care issue presented.
5. The Quality Medical Director or his/her designee will institute needed or corrective action plans when potential problems or poor performance is detected. The Quality Medical Director will work collaboratively with the Credentialing Chairperson, or designee to identify, monitor and resolve issues or concerns. The Quality Medical Director has the discretion to forward these cases for peer review.

Designated Behavioral Health Care Practitioner

The Medical Director of the Medical Group's contracted Behavioral Health Care provider shall be available for assistance with member behavioral health complaints.

Quality Director and/or Quality Manager

The Quality Director and/or Quality Manager are designated as having the primary responsibility for oversight of the grievance program, and shall continuously review the operations of the program to identify any emergent patterns of complaints to improve service/care, and to improve our policies and procedures.

The Quality Director and/or Quality Manager shall have the direct responsibility to oversee and monitor all complaints received. They will identify and report patterns of complaints to the Quality Medical Director and Quality Committee to formulate policy changes and procedural improvement.

Customer Service Director and/or Customer Service Manager

The Customer Service Director and/or Customer Service Manager shall oversee and monitor all inquiries and statements of concerns received. The member shall be directed to and/or assisted in filing a complaint with the Health Plan. The Customer Service Director/Manager or their designee will identify and report patterns of member inquiries and statements of concerns to formulate policy changes and procedural improvements.

Other Management

Other management shall be responsible for the operational area that is subject to the complaint received. They shall promptly review the complaint, conduct an internal investigation, and provide a written detailed report to the Quality Director and/or Quality Manager.

QI COMMITTEE FUNCTION

The Quality Improvement Committee oversees the functioning of the grievance program and activities conducted by the Designated Physician and the assigned Quality Management staff. This Committee is composed of participating practitioners who represent primary care and commonly used specialties and shall be responsible to:

1. Develop, implement and oversee the grievance program.
2. Direct the investigation of identified and suspected problems and to direct the responsible parties to implement action.
3. Recommend corrective action for resolution of grievances.
4. Institute corrective action for cases where serious harm and injury have occurred to the member.
5. Recommend education/training programs.
6. Recommend new policies and/or procedures, or policy, procedure, and/or program changes based on their findings.
7. Recommend follow-up with the member and assistance as needed to ensure that the immediate health care needs are met.
8. Conduct periodic review of complaints received, no less than quarterly.
9. Maintain written records.
10. Track and trend complaints, statements of concerns, and potential quality issues.

The Quality Committee will ensure follow-up as appropriate on potential problems or poor performance until resolution is achieved and interventions are implemented to prevent future recurrences.

GRIEVANCE PROCESS

Routing Grievances to the Health Plan

HPN, the Medical Groups, each contracted facility, and practitioner shall direct its members or the member's representative to their respective Health Plan and instruct him/her how to file a complaint with the plan. Complaint forms and a brief description of the complaint procedure shall be provided with the Health Plan's mailing address, URL address, and toll-free telephone number or local telephone number and readily available to the member upon request.

All complaints received by mail, email, and telephone must be forwarded to the Health Plan for handling.

By Mail or Email

For member complaints received by U.S. mail, the envelope and letter shall be date stamped. The letter shall for forwarded the same day to the Health Plan for processing. Documentation provided must include if received in writing, who received, date received and issue. HPN does not advise receiving or sending PII and PHI information via e-mail. The member will be referred to contact the Health Plan's Customer Service representative for filing.

By Telephone

The Group's Customer Service Representative will assist the member in filing a complaint to the Health Plan using one of the following methods:

1. Providing the member with the Health Plan's Customer Service telephone number which is located at the back of the membership card and/or referencing to the "HPN Health Plan Contact List."
2. Directing the member to the Health Plan's website to their on-line form. The member shall

be assisted to complete the on-line form, as needed.
3. Providing the member with the Health Plan's mailing address. A form can be mailed to the member upon request and based on their language preference.
4. Warm transfer of the member to the Health Plan's Member Services representative.

Support for Filing Grievances for Hearing and Speech Impaired Members

All members with hearing and speech impairment shall be provided with assistance. Such assistance shall include, but is not limited to TDD telephone number, translations of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.

Support for Filing Grievances for Members with Linguistic and Cultural Needs

The grievance system shall ensure all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment.

Such assistance shall include, but is not limited to, translations of complaint procedures and forms, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. Complaint forms shall be available in Spanish and English, and/or the member's language of choice. They shall be made easily accessible to the member on-line and in print and be readily available at the member's request.

Receipt of Grievances from the Health Plan

HPN is not delegated to resolve grievances but will assist the Health Plan in the resolution of the grievances received. Complaints are sent to the Quality Improvement (QI) Department from the full-service Health Plan via facsimile or secured email. A worksheet/form will be prepared by the assigned QI staff upon receipt of the complaint from the Health Plan to document the details of the complaint.

Coding of Grievances

Each grievance will be coded by category and subcategory, which will be used in tracking to identify provider-specific and system-wide trends that may need corrective action. Codes at a minimum will include:

1. ***Quality of Care:*** A quality of care grievance is a type of grievance that is related to whether the services provided by a plan or provider meets professionally recognized standards of health care.
2. ***Access:*** Access complaints are real or perceived complaint by the member, his/her family member, or their authorized representative of difficulty in accessing services. Service delivery includes: the provider, the specialist, the facility, any ancillary services, and all departments within the Medical Group.
3. ***Customer Service***: Customer service complaints are taken very seriously. Any violation of a member's rights, and/or other heinous acts taken against the member shall be reported immediately to the appropriate regulatory authority to include: Child or Adult Protective

Services, County, State or Federal agency, the Attorney General's Office, and law enforcement for further research/review or action.

4. ***Provider Office Site***: An on-site visit must be conducted for all practitioner office site complaints. The HPN template shall be used by the Medical Group for all on-site surveys. It is recommended that two representatives conduct the survey, with at least one (1) individual being a licensed clinical person, as clinically indicated. Any violation of County, State or Federal rules must be reported, immediately. This includes the Occupational and Health Safety Administration (OSHA) and county Sanitation departments.

Record Maintenance

A written case record shall be maintained for each grievance received by the Medical Group, including:

1. The member's name
2. A general description of the reason for the grievance
3. The date each grievance was received
4. The date of each review, or, if applicable, the review meeting
5. The decision or resolution of the grievance
6. The date of the decision or resolution of the grievance

Any communication to the member regarding the grievance will be completed by the full-service Health Plan.

Internal Investigation of Complaints

The Medical Group shall conduct an internal review of all complaints received. This process is as follows:

1. Complaint received by secure email or facsimile from the Health Plan.
2. Medical Group representative fills out the worksheet, noting the complaint as stated by the complainant in quotation marks.
3. A case "incident" file is opened in the applicable customer service module, indicating the date received.
4. Quality of care issues are identified and a preliminary assessment of the severity of the issue is completed.
5. Prioritization of action(s) needed to resolve immediate care needs, when appropriate.
6. Request of medical records and supporting documents from the provider(s) relevant to the case.
7. Request of provider response. Openly communicate with the involved provider(s) to obtain their written response to the allegation.
8. Documentation of any/all conversations relevant to the case in the relevant data base system.
9. Research, including, but not limited to a review of the event(s), documentation of conversations, quantitative and qualitative analysis of the research, which may include root cause analysis. Examination of medical records upon receipt, and communication with involved provider(s) if additional information is required.
10. The case file is forwarded to the assigned physician reviewer.

Physician Review of Complaints

The Physician reviewer shall:

1. Review the complaint received.
2. Review the provider's previous history of compliance, and/or quality of care issues.
3. Review trend reports.
4. Conduct research, including, but not limited to a review of the log of events, documentation of conversations, and medical records review, mortality review, etc.
5. Complete a quantitative and qualitative analysis of the research, which may include root cause analysis.
6. Prioritize action(s) needed to resolve immediate care needs when appropriate.
7. Record his/her expert opinion; and criteria used to make determination. A written response from or summary of the documents received.
8. Assign a severity level (complaints only).
9. Determine if the complaint was substantiated, unsubstantiated, or unable to determine.
10. Recommend interventions to resolve and prevent similar incidences from recurring.
11. Determine if the complaint shall be forwarded to the department management responsible for the deficient operational area that is the subject of the complaint or appeal review.
12. Determine if the complaint shall be forwarded to the Quality and/or Credentialing committee(s) for additional peer review.
13. Report his findings to the Quality and/or Credentialing committees.
14. Report to the Health Plan, if indicated.
15. Report to the appropriate County, State or Federal regulatory authority and/or agency, if indicated.

The Quality and/or Credentialing Committee(s) shall review individual cases resulting in member harm. This shall be done on a case-by-case basis, relating to individual or practice issues. The Committee(s) may refer cases to non-affiliated specialty providers for review and recommendations.

Documentation of Grievance Outcome

The Medical Director or assigned physician reviewer will assign a grievance resolution status for each grievance received. The status codes are:

1. **In Favor** – The complaint was "Substantiated" and found in favor of the member.
2. **Not In Favor** – The complaint was "Not Substantiated" and found in favor of the provider or Medical Group.
3. **Unable to determine** – There was insufficient evidence to make a determination, and the Medical Group was "Unable to Substantiate" the member's complaint.
4. **Withdrawn** – The complaint was withdrawn at the Health Plan level by the complainant.
5. **Dismissed** – The complaint was dismissed at the Health Plan level by the Health Plan
6. **Null** – a case remains open.

Severity Leveling

Upon completion of the investigation the individual case is assigned a severity level according to the Severity Leveling Table below. The table identifies criteria for each severity level and associated corrective action. Each level of severity is accumulated and tracked for each provider. Once trends are identified, corrective actions are implemented against the provider.

Table 1. Severity Leveling & Action Plans for Quality Management Committee Cases

Level	Description	Examples	Severity Level may be assigned by:	Corrective Action	Evidentiary Documents and Follow-up to Include:
0	No quality of care issue identified.	Example: Patient medical record in total conflict with complaint	Quality Director / Manager Physician Reviewer Medical Director Quality Improvement Committee	Track At Minimum Letter to Physician of Findings and Outcome Educational Letter, As Appropriate	• Initial Grievance Notice from Health Plan • Completed Grievance Form • Supporting Documents • Letter to Physician • Education Letter, if applicable • Quarterly Grievance Report to QIC • Annual QIC Provider Performance Monitoring Worksheet
1	Member experienced adverse administrative issue(s), attitude/communications issue(s) or known/expected complication(s) occurred that is not due to negligence or poor/improper technique.	Example: Liver biopsy performed with hemorrhage resulting in death one-week post op (no indication in op report of intraoperative complications; known complication)	Physician Reviewer Medical Director Quality Improvement Committee	Track At Minimum Letter to Physician of Findings and Outcome Educational letter, as Appropriate	• Initial Grievance Notice from Health Plan • Completed Grievance Form • Supporting Documents • Letter to Physician • Education Letter, if applicable • Quarterly Grievance Report to QIC • Annual QIC Provider Performance Monitoring Worksheet

Level	Description	Examples	Severity Level may be assigned by:	Corrective Action	Evidentiary Documents and Follow-up to Include:
2	Confirmed quality issue in which care had potential for minimal to moderate adverse effect(s) on the patient.	Example: Inadequate medical record documentation Mildly abnormal lab findings and no indication of appropriate follow-up Issues that are identified for tracking and trending	Physician Reviewer Medical Director Quality Improvement Committee	Track for further occurrence Letter to Physician of Findings and Outcome Implementation of new, or change in existing policies Individual verbal counseling	• Initial Grievance Notice from Health Plan • Completed Grievance Form • Supporting Documents • Letter to Physician • Education Letter, if applicable • Notation/Summary report of verbal 1:1 • Counseling signed by Physician • P&P new or revision to existing • Quarterly Grievance Report to QIC Annual • QIC Provider Performance Monitoring Worksheet

Level	Description	Examples	Severity Level may be assigned by:	Corrective Action	Evidentiary Documents and Follow-up to Include:
3	Confirmed quality issue which resulted in minimal to moderate adverse effect(s) on the patient.	Example: Emotional distress Prolonged treatment	Physician Reviewer Medical Director Quality Improvement Committee	Track for further occurrence Letter to Physician of Findings and Outcome Ongoing monitoring Implementation of new, or change in existing policies Individual verbal counseling Individual written counseling "Lessons Learned" presentation to staff	• Initial Grievance Notice from Health Plan • Completed Grievance Form • Supporting Documents • Letter to Physician • Education Letter, if applicable • Notation/Summary report of verbal 1:1 • Counseling signed by Physician • Written Warning signed by Physician • Ongoing Sanction/Complaint Log • QIC Meeting Minutes • "Lessons Learned" presentation • P&P new or revision to existing • Quarterly Grievance Report to QIC • Annual QIC Provider Performance Monitoring Worksheet

Level	Description	Examples	Severity Level may be assigned by:	Corrective Action	Evidentiary Documents and Follow-up to Include:
4	Confirmed quality issue in which care had potential for a significant adverse effect(s) on the patient or resulted in moderate adverse effect(s).	Example: "Potential": Evidence of inappropriate administration of IV fluids (e.g., incorrect rate or fluid), medication error. Corrected prior to development of significant complication	Physician Reviewer Medical Director Credentialing Committee Quality Improvement Committee	Track for further occurrence Letter to Physician of Findings and Outcome Ongoing monitoring Implementation of new, or change in existing policies Individual written counseling Mandated CMEs Establishment of preceptor program Limitation of privileges Report to Credentialing	• Initial Grievance Notice from Health Plan • Completed Grievance Form • Supporting Documents • Initial Letter to Physician of findings and CAP • Written Warning signed by Physician • Quarterly Monitoring Letters • Ongoing Sanction / Complaint log • Evidence of completion of CMEs • Evidence of completion of Preceptor Program • QIC Meeting Minutes • Peer Review Meeting Minutes • "Lessons Learned" presentation • P&P new or revision to existing • Quarterly Grievance Report to QIC • Annual QIC Provider Performance Monitoring Worksheet

Level	Description	Examples	Severity Level may be assigned by:	Corrective Action	Evidentiary Documents and Follow-up to Include:
5	Confirmed quality issue in which care resulted in significant adverse effect(s) on the patient.	Example: "Resulted": Evidence of inappropriate administration of IV fluids (e.g., incorrect rate or fluid), medication error. Errors not corrected in a timely manner and significant harm results (e.g., pulmonary edema, CHF)	Physician Reviewer Medical Director Credentialing Committee Quality Improvement Committee	Track for further occurrence Letter to Physician of Findings and Outcome Ongoing monitoring Implementation of new, or change in existing policies Individual written counseling Mandated CMEs Establishment of preceptor program Limitation of privileges Report to Credentialing	• Initial Grievance Notice from Health Plan • Completed Grievance Form • Supporting Documents • Initial Letter to Physician of findings and CAP • Written Warning signed by Physician • Quarterly Monitoring Letters • Ongoing Sanction / Complaint log • Evidence of completion of CMEs • Evidence of completion of Preceptor Program • QIC Meeting Minutes • Peer Review Meeting Minutes • "Lessons Learned" presentation • P&P new or revision to existing • Quarterly Grievance Report to QIC • Annual QIC Provider Performance Monitoring Worksheet
6	Confirmed quality issue in which care	Example: Patient presented with	Physician Reviewer Medical	Track occurrences Letter to Physician	• Evidentiary Documentation is dependent on Peer

Level	Description	Examples	Severity Level may be assigned by:	Corrective Action	Evidentiary Documents and Follow-up to Include:
	patient mortality.	signs and symptoms of an MI and no cardiac work up occurred. Patient treated for gastric distress. Resulting in acute MI with subsequent mortality	Credentialing Committee Quality Improvement Committee	Findings and Outcome Ongoing Monitoring Implementation of new, or change in existing policies Individual written counseling Mandated CMEs Establishment of preceptor program Limitation of privileges Termination of participation Report to Credentialing May Report to MBOC	determination • Initial Grievance Notice from Health Plan • Completed Grievance Form • Supporting Documents • Initial Letter to Physician of findings and CAP • Letter of termination of participation, as applicable • MBOC 805 report, as applicable • Written Warning signed by Physician • Quarterly Monitoring Letters • Ongoing Sanction / Complaint log • Evidence of completion of CMEs • Evidence of completion of Preceptor Program • QIC Meeting Minutes • Peer Review Meeting Minutes • "Lessons Learned" presentation • P&P new or revision to existing • Quarterly Grievance Report to QIC • Annual QIC Provider Performance Monitoring Worksheet

Feedback with Members

The Medical Group is not delegated for member communication for complaints. Member communication regarding the disposition of each complaint received is maintained by the full-service Health Plan.

At the conclusion of each complaint received the Medical Group may follow-up with the member to ensure their needs were adequately met and to coordinate their care. This may include, but is not limited to:

1. Advocating for the member and providing assistance to ensure that their immediate healthcare needs are met.
2. Coordinating care conferences to discuss the member's and/or caregiver's needs.
3. Providing member counseling, and education on processes or health care needs.
4. Establishing a member contract agreement.
5. Changing their placement.
6. Changing their provider.
7. Making changes to their treatment plan.
8. Immediate authorization of services, if previously denied. To include a telephone, call the same business day, notifying the member of the reversal of the initial determination.

Feedback to Providers

Providers receive feedback on quality assurance activities, including results of grievances received, and credentialing quality reviews. Feedback may occur as written counseling, notification of corrective action plans, notification of system-wide policy and procedure changes, or provider profiling reports.

REQUEST FOR RECONSIDERATION

The provider has the opportunity to request reconsideration of any complaint received, resulting in sanctions or penalties against the provider. The provider's request must be made in writing. The request and any supporting documentation are to be submitted to the Medical Director, or designee for appropriate re-review. It shall be presented at the Credentialing Peer Review committee for reconsideration. Decisions made by the Credentialing Peer Review committee on reconsiderations are considered final.

CORRECTIVE ACTION

The Medical Group may take action to correct both individual problems and patterns of problems in the delivery system. HPN has defined the types of issues requiring corrective action and the types of corrective actions to be taken. Each individual corrective action includes the responsible party and a timetable for completion. In the event of non-compliance, the corrective action is intensified up to and including termination.

Medical Director and/or Committee Actions for Complaints Received:

1. ***No Action Needed***
2. ***An Education Letter to the provider***: This may include, but is not limited to, in-service attendance sheets and training objectives. A copy of the letter must be retained in the case file.
3. ***Verbal Counseling:*** there must be a documented record of the verbal counseling, to include

a letter to the provider reiterating what was stated.

4. ***Corrective Action Plan (CAP):*** A letter to the provider with attached CAP with a due date for completion, generally within ten (10) business days. There must be follow-up visit by a Medical Group representative(s) to ensure that the corrective action was completed.
5. ***Written Counseling or Directive:*** A letter to the provider stating the actions that must be taken and the time frame for completion. There must be documented evidence of follow-up by the Medical Group that corrective action was completed.
6. ***Intensified Retrospective Review:*** The Medical Group may conduct a detailed retrospective review of the complaints received. A retrospective review may include the review of the member's records. A determination will be made by committee based on the findings.
7. ***Concurrent Review:*** The Medical Group may conduct a detailed concurrent review of all complaints received, against a provider. A proctor will be identified to review the member's medical record, and actually observe the physician's work. A determination will be made by the committee based on the findings.
8. ***Prospective Proctoring:*** A review by the proctor of the member's chart and the member personally before treatment. The proctor must have the clinical expertise, and experience to accurately evaluate the provider's performance. The proctor shall validate whether or not the provider is competent. The proctor shall assess the provider's clinical knowledge, knowledge of the equipment; and knowledge of the procedure.
9. ***Panel Review:*** The Medical Director shall appoint three (3) unbiased physicians, each with the clinical expertise and experience, to adjudicate the case. The panel shall meet, review the case file, and make a final determination. Refer to "Attachment A" for Guideline.
10. ***Mandatory CEUs:*** The Medical Director, per recommendations from the QIC and Credentialing committee(s), shall ensure enrollment of the provider into a continuing education class respective to the complaint filed. The provider shall submit evidence of completion. A record shall be maintained, to include certificate of completion.

Assessment of Effectiveness of Corrective Action

Upon completion of corrective action, the QM department continues to monitor quality of care complaints filed against the identified provider. A focused audit may also be conducted to determine the effectiveness of corrective action. This information is forwarded to the QM Medical Director for his/her determination of decline or cessation of the related issue.

In cases in which the established corrective action does not appear to have been effective, the QM Medical Director presents the issue(s) to the peer review committee for recommendations as to further action. Such action may include, but not be limited to, those identified in the Severity Leveling Table. For system-wide policy and procedures changes, the QM department assesses the effectiveness of system modifications through monitoring of quality of care complaints. A focused audit may also be conducted to determine effectiveness.

COORDINATION WITH RISK MANAGEMENT

For cases identified as potential risk management issues, the QM Department advises the Corporate Compliance / Legal Department of the issue and forwards the case file for review. Corporate Compliance and Quality Management coordinate their efforts where they overlap to ensure better alignment of patient

safety initiatives and use of resources.

COORDINATION WITH CREDENTIALING

The Credentialing Department maintains a Sanction log of all actions taken against physicians.

A grievance trend report is forwarded to the Credentialing Chair for review and determination as to whether or not actions should be taken against a practitioner/facility organization. This report is reviewed annually and is trended for three consecutive years. The report contains the following information:

1. The provider was placed on a corrective action plan for a quality of care issue
2. There were multiple grievances filed against the provider
3. The severity of grievances filed against the provider
4. Any utilization management issues of over and under utilization
5. Member satisfaction surveys demonstrated levels of dissatisfaction
6. The provider was limited in his/her privileges
7. Report filed against the provider to the Board of Medical Examiners
8. Report filed against the provider to the Board of Dental Examiners
9. Loss of Medicaid and/or Medicare privileges

DISPUTE RESOLUTION PROCESS FOR PROFESSIONAL COMPETENCE OR CONDUCT

The Medical Group may terminate a provider for professional competency and/or conduct, or quality of care issues; and may do immediate suspension or termination for concerns for consumer safety. The Medical Group must notify the Health Plan immediately of all termination based on competence or conduct.

Terminations for professional competency, conduct or quality of care

Contracted providers may dispute the Medical Group's decision to terminate a contract for lack of professional competence or for professional misconduct. Examples of these disputes include, but are not limited to:

1. Belief that a quality of care issues exists
2. Adverse action taken by a hospital
3. Disciplinary action taken by a licensing board
4. Trend or pattern of quality of care issues

If a provider is terminated for professional competency and/or conduct:

1. The provider will be notified in writing of the reason for the termination
2. The provider may request reconsideration in writing not later than 30 calendar days after receipt of notice of termination
3. The Credentialing Committee, consisting of at least three (3) qualified individuals with at least one (1) participating clinical peer provider, will consider the reconsideration request
4. The Committee will notify the provider within 10 business days of its decision
5. If the provider is not satisfied with the committee decision, a second level appeal may be requested not later than 30 calendar days of the receipt of the committee decision

6. A panel of three (3) individuals, who did not participate in the first level decision, including at least one participating provider who is a clinical peer of the appealing provider, will consider the second level appeal
7. The panel's decision is final and will be communicated to the provider in writing, via certified mail, within 10 business days of the decision

Immediate Suspension or Termination Related to Concerns for Consumer Safety

If a Medical Director believes a provider is practicing in a manner that poses a significant risk to the health, welfare, or safety of consumers, the Medical Group can either immediately suspend or terminate the provider.

If the circumstances require an investigation to know whether the concerns are justified, the Medical Group will immediately suspend the provider contract and conduct an expedited investigation. If the circumstances do not require an investigation to know whether the concerns are justified, the Medical Group will immediately terminate the provider contract.

Examples of circumstances that might result in immediate suspension or termination include, but are not limited to:

1. Insufficient or no professional liability insurance
2. Sanction by Medicare/Medicaid
3. Exclusion from any Federal Programs
4. A change in license status
5. Fraudulent activity

When a suspension or termination occurs:

1. The provider is immediately removed from the provider directory.
2. The provider is notified of the suspension or termination in writing. The notification will include the reason for the suspension or termination.
3. The provider may request reconsideration in writing not later than 30 calendar days after receipt of notice of termination.
4. The Credentialing Committee, consisting of at least 3 qualified individuals with at least one participating provider who is a clinical peer, will consider the reconsideration request.
5. The Committee will notify the provider within 10 business days of the decision.
6. If the provider is not satisfied with the committee decision, a second level appeal may be requested not later than 30 calendar days of the receipt of the Committee decision.
7. A panel of three individuals, who did not participate in the first level decision, including at least one participating provider who is a clinical peer, will consider the second level appeal.
8. The panel's decision is final and will be communicated to the provider in writing, via certified mail, within 10 business days.

DISPUTE RESOLUTION PROCESS FOR ADMINISTRATIVE MATTERS

Disputes regarding administrative matters may arise when a contracted provider wishes to protest the Medical Group’s decision that the provider has breached the provider's participation agreement or violated of Medical Group policy. Examples of administrative disputes include, but are not limited to:

1. Non-compliance with administrative terms in the participation agreement or Provider Operating Guide
2. Billing the member improperly
3. Failure to submit requested medical records

When an administrative dispute occurs:

1. The Medical Group will send a letter to the provider detailing the contractual breach or administrative violation
2. The provider may request reconsideration in writing not later than 30 days after receipt of the notice
3. An authorized representative of the organization not involved in the initial decision on the subject of the dispute will consider the written reconsideration
4. The authorized representative's decision is final and will be communicated to the provider in writing within 30 calendar days

REPORTING TO HEALTH PLAN

If an adverse action is against a practitioner/facility organization due to a quality of care concern, the Medical Group will report the adverse action to the Health Plan when the practitioner's or facility organization's affiliation with the Medical Group is suspended or terminated because of quality of care issues.

1. The Medical Group will report to the Health Plan any deviation or suspected deviation from State or Federal program requirements or regulations that impact one or more beneficiaries.
2. The Medical Group will fully disclose to the Health Plan all circumstances surrounding the event to assist them in the completion of their investigation.
3. The Health Plan will be notified upon discovery for all events that place the member in immediate jeopardy.
4. The Health Plan will be notified verbally and in writing within 24 hours of all other incidents. All documents relevant to the case shall be obtained by the Quality Department in collaboration with the Risk Department.
5. The case documents shall be submitted to the Health Plan within seven (7) days of incident.
6. The Medical Group will cooperate with Federal and State designated agencies, and the Health Plan in the resolution, and closure of all events resulting in harm to the member.

REPORTING TO REGULATORY AGENCIES

The Medical Group may notify and report to appropriate regulatory agency; Child or Adult Protective Services, the respective State and Federal agency and licensing agency, the Attorney General's Office, Child or Adult Protective Service, and/or law enforcement agency for further research/review or action on statements of concerns or complaints, received which resulted in an adverse negative outcome to the member.

Initial reporting may be made verbally but must be followed by a written report within one (1) business day. The Medical Group must ensure that member health records are available and accessible to authorized staff of their organization and to appropriate State and Federal authorities, or their delegates. Member record availability and accessibility must be in compliance with Federal and State

confidentiality laws. Information must be available to regulatory agencies upon request.

TRACKING AND TRENDING

HPN annually analyzes complaints and appeal data to look for opportunities for improvement among the categories of:

1. Quality of Care
2. Access
3. Attitude and Service
4. Billing and Financial Issues
5. Quality of Practitioner Office Site

HPN and the Medical Groups also track quality of care investigations to identify trends or patterns of issues that may be either provider specific or system wide. If significant negative trends are noted, the issue may be considered as the topic for a performance improvement activity to improve the issue resolution process itself, and to make improvements that address other system issues raised in the resolution process.

The grievance system will track grievances under categories of Commercial, Medicare, and Medicaid/other contracts. For those individual case reviews that are presented to the peer review committee, a provider trend/pattern report is prepared. This report is made available to the committee during the corrective action discussion of the case to ensure appropriate progressive corrective action.

1. On a quarterly basis, category reports are prepared for a rolling 12-month period. These reports are analyzed prior to the committee meetings by the Quality Management Director and/or Manager and the Medical Director to determine potential system-wide problems that may need a change in policy and procedure.
2. On a quarterly basis, provider profiling tracks the total number of complaints and concerns for individual providers and identifies outliers.
3. On a quarterly basis, provider-specific reports by issue category are prepared for a rolling 12- month period.
4. On a quarterly basis, HPN submits a report of Grievances we have received through our internet portal. As HPN is not delegated for Appeals and Grievances, only the number of grievances received is reported as the Health Plans are responsible for review processes and fair hearing. These reports are verified by an officer authorized to act on behalf of the plan and placed on the appropriate quarterly form and submitted through electronic filing to the DMHC within 30 days after each quarter.

These reports are analyzed by the QM Director/Manager and the Medical Director to determine potential trends/patterns by individual provider. For those providers who appear to have a problem with his/her practice pattern as identified by multiple occurrences in the same category, the Medical Director may institute corrective action.

1. The grievance systems shall track, and monitor grievances received by each respective Health Plan. The report shall be presented to the QI and Credentialing Committee quarterly for review.
2. The QIC shall conduct an aggregate analysis of grievances to track and trend potential

issues and barriers to care.
3. Evidence of review will be documented in the committee meeting minutes. Meeting minutes will be signed by the respective committee chairperson and the Medical Director and/or Quality Director/Manager.

Reports submitted to the Quality Committee shall include and not be limited to:

1. Track the number of grievances
2. Track grievances by category, and sub-type
3. Track grievances PKPM
4. Track grievances by LOB
5. Total # grievances per provider
6. Logs of grievances received, and forwarded to the Health Plan for resolution

PROGRAM EVALUATION

There is an annual written evaluation of the complaints received and the overall effectiveness of the program that is reviewed and approved by the Quality Committee. Benchmark goals are established by HPN and each Medical Group which is noted in their evaluation. The program evaluation includes:

1. A summary of aggregate scores and ongoing activities that address the quality and safety of clinical care and quality of service.
2. A trending of measures to assess performance in the quality and safety of clinical care and quality of service.
3. An analysis of the results, including barrier analysis.
4. An evaluation of the overall effectiveness of the Grievance Program, including progress toward influencing network-wide safe clinical practices
5. The impact the process has had on the need for Grievance Program revisions and modifications
6. Findings that will be used to develop and improve member satisfaction for the upcoming year

If significant negative trends are noted, HPN and the Medical Group will consider making it the topic for one of its performance improvement activities to improve the issue resolution process, and to make improvements that address other system issues found.

APPENDIX: COMPLAINT TIMEFRAMES

The Health Plan, State, and Federal agencies have set time frames by which we must adhere to. Each complaint received must meet the specified turn-around-times for completion for each element.

Complaint Time Frames	Commercial	Medicaid	Medicare Advantage
Upon Discovery by Customer Service Department and/or another department.	Phone: Refer Member to the Health Plan, State, or Federal agency for filing. Letter: Must be forwarded within 24 hours to the Health Plan.	Phone: Refer Member to the Health Plan, State, or Federal agency for filing. Letter: Must be forwarded within 24 hours to the Health Plan.	Phone: Refer Member to the Health Plan, State, or Federal agency for filing. Letter: Must be forwarded within 24 hours to the Health Plan.
Filing **Member filing of complaint from date of incidence.**	Health Plan 180 days	Health Plan Anytime	Health Plan ** 60 days after the incident that precipitates the grievance.
Acknowledgement **Receipt of Complaint from Health Plan and Collecting of Documents.**	Forward to Health Plan within time frames specified, not to exceed 5 business days	Forward to Health Plan within time frames specified, not to exceed 5 business days	Forward to Health Plan within time frames specified, not to exceed 5 business days
Standard Resolution **Completion of Internal Investigation,** including leveling and determination.	30 calendar days	30 calendar days (State)	30 days of receipt of the request (Federal) *(Verbal & Written request)*
Notification to Member			**Standard** - No later than 30 days **Expedited** - No later than 24 hours from receipt with written confirmation & within 3 calendar days from verbal notification
Expedited Resolution	3 calendar days	72 hours	24 hours *(Verbal & Written request)*
Corrective Action Plan Implemented. The practitioner and/or facility is required to submit a corrective action plan if they are at fault.	45 calendar days of the event	45 calendar days of the event	45 calendar days of the event

For the purpose of assessing the timeliness of a plan's completion of a grievance, initial determination, or reconsideration, the day a plan receives the request is not counted as "day one". "Day one" is the day after receipt of the request. (Day/days are calendar days unless otherwise specified and includes weekends and holidays). Timeframes measured in hours must be met within the number of hours indicated.

*** A Plan may but is not required to accept and process a grievance that is files after the 60-day deadline. If the plan chooses not to accept untimely filing, they may dismiss the grievance.*