Policy Title:	Quality of Care Investigations
Department:	Clinical Quality Improvement
Policy Number:	CQI-21
Issue Day:	Effective Date:
Next Review Date: 10/1/21	Revision Dates:

Clover

Approved By:		
		10/22/2020
Julianne Eckert, RN BSN - Director of Clinical Quality Improvement		*Date*

REFERENCE:	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)

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

Scope: Medicare Advantage Part C

Policy: Clover has established and maintains a grievance/complaint procedure for the timely addressing of quality of care grievances and complaints that do not involve organizational determinations. A member may file a quality of care complaint/grievance with Clover 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.

For quality of care grievances submitted to the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), plans must cooperate with the BFCC-QIO and comply with requirements of 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 plan. In the event that the member concern was sent to both Clover and the regional BFCC-QIO,

it is the obligation of Clover to collaborate with the BFCC-QIO in the investigation and resolution.

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

Clover may, but is not required to, accept and process a quality of care grievance that is filed after the 60-day deadline. If Clover chooses not to accept untimely filing, they may dismiss the quality of care grievance.

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, tracked for purpose of possible sanction, and resolved/responded to in writing within 30 days of receipt, or as expeditiously as the member’s health condition requires. Clover will use the minimal necessary information to investigate and evaluate the complaint.

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

Clover 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, the MA organization must cooperate with the BFCC-QIO in resolving the complaint.

Recordkeeping:
The MA organization 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 Clover notified the member of the disposition.

Part D Quality of Care complaints/grievances:
Part D quality of care complaints are handled by Clover’s Pharmacy Benefits Manager (PBM).

Definitions:

Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO): Organizations comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare members. The BFCCQIOs 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 hospital 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 Care 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 coverage 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 or other party involved in a grievance, organization determination, or appeal. Under Part D, as defined in §423.560 as “appointed representative”, an individual either appointed by an member or authorized under state or other applicable law to act on behalf of the member in filing a grievance, obtaining a 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 of the rights and responsibilities of a 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 an 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.

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 electronic system to determine if Clover 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 isn't 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 Clover 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 Investigation folder and the case will be closed based on the date/time of the sent Dismissal letter.

- **Referrals:**
  - Quality of care complaints/complaints can be referred by physician reviewers and/or health care professionals such a Medical Management nurse. These QOC complaints/grievances are first referred to the Grievance team who will review the complaint/grievance as "founded" or "unfounded".
    - The Grievance team will then email founded QOCs to QOC@cloverhealth.com.
  - Upon receipt of a QOC grievance/complaint in QOC@cloverhealth.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 Clover, the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), or both.
    - For any grievance submitted to the BFCC-QIO, Clover must cooperate with the BFCC-QIO in resolving the grievance, including directing providers to respond to BFCC-QIO requests for information, within 14 days. Clover should provide any records and requested information as quickly as possible and within 14 days.

- **Documentation of QOC complaint/request**
  - For the entirety of the QOC complaint/grievance process, once a case is received to QOC@cloverhealth.com, all information will be 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 member phone calls recordings, letter correspondence, emails, faxed requests including timestamps will be archived in the restricted QI QOC investigation folder, and each document/call recording etc, will be linked within the QOC investigation 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 the 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 or receipt of complaint/grievance. Additional medical records may be requested as determined by the QI Clinical Nurse Reviewer.

- If information is not received at Clover within 14 calendar days of the request, the Quality Improvement 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 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 in efforts to retrieve the requested medical records.

o Upon receipt of the relevant medical records, the QI Coordinator will do an initial review of the documentation to ensure completeness and will forward all case documentation to the QI Clinical Nurse Reviewer for review and provisional/recommended severity assignment from a Level 0 to Level 4.

o All Medical Record requests and receipts of information will be tracked in the QOC Investigation Tracker and within the restricted QI QOC investigation folder. Links to Medical Records will be embedded within the QOC investigation tracker.

- **<u>Time frame Extensions</u>**
    - o If the QI team needs more than 30 days to investigate and resolve a standard QOC grievance/complaint, and that additional time is in the member's best interest, 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 the plan is extending the process by cannot be more than 14 calendar days.

- **Medical Record Review**
    - o If information is received, the Quality Improvement (QI) Clinical Nurse Reviewer conducts a review and evaluation of the issue and documents within the QOC Investigation tracker.
    - o If the information is not received, the QI Clinical Nurse Reviewer will notate on the QOC Investigation Tracker.
    - o All cases, regardless of whether medical records were received or not, will be brought to the Senior Medical Director and Director of QI once the review is completed by the QI Clinical Nurse Reviewer.
        - The Clinical Nurse Reviewer will place the case on agenda for weekly review with the Senior Medical Director and Director, Quality Improvement.
- **Senior Medical Director and Director, Quality Improvement Review**
    - o Once Medical Record Review is completed (with or without receipt of requested medical records) the case is forwarded to the Senior Medical Director and Director, Quality Improvement for presentation, final review and recommendations for next steps/interventions, as well as Final Severity code.

- The Senior Medical Director and Director, Quality Improvement will review the concern and evaluation prepared by the QI Clinical Nurse Reviewer as well as supporting documentation and will finalize the case severity score:

- **QOC Review Outcomes and interventions**
  - Once Senior Medical Director and Director, Quality Improvement have reviewed case, additional intervention steps may be taken per their direction including but not limited too:
    - Referral to Clinical Programs for Coordination of Care needs, provider/specialist scheduling assist, etc.
    - If the provisional score is 2a or higher, a letter, signed by the Senior Medical Director is sent to the provider with case resolution and further action plan. A copy of the letter is emailed to the Credentialing Manager and is included in the provider credentialing file.
    - If the provisional score is 2b or higher, the Senior Medical Director 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 file and the Credentialing department is notified of the outcome of the Peer Group review by the Senior Medical Director.
      - 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 Senior Medical Director and Director, Quality Improvement 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 a 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 a severity score cannot be assessed, the resolution letter will include all of the available information based on the case research, including our attempts to obtain the requested information, along with the instructions on contacting the BFCC-QIO for further assistance
    - Network team is notified of case outcomes for tracking/trending.
  - All documentation is retained in the Quality of Care Investigation Tracker and the member folder located within the restricted Quality of Care Investigation folder.

- **Written Notice (Resolution Letter):**
  - Written notice must:
    - Include a description of the member's right to file a grievance with the BFCC-QIO and contact information for the BFCC-QIO; and
    - Be written in a manner that is understandable to the member.
    - 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 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 Clover.
  - If submitted to the BFCC-QIO only, it is the BFCC-QIOs 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 Clover.
  - If submitted to Clover and the BFCC-QIO, the investigation and resolution must be conducted in full collaboration. Clover will take the lead in the process.

  - For grievances submitted to the BFCC-QIO, plans must cooperate with the BFCC-QIO and comply with 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 plan.

- **Procedures for handling withdrawn quality of care grievance/complaint**
  - If the member submits a quality of care grievance verbally or in writing, but later decides to withdraw the grievance, the plan is still required to investigate the quality of care grievance; however, the plan is not required to notify the member of the outcome of the grievance since they decided not to pursue the grievance.
    - At any time during the grievance process before the decision is delivered, the member may submit a written withdrawal request for a grievance any time before the decision is mailed by the plan.
    - Clover 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 will be taken:
      - The request for withdrawal will clearly be documented in the Quality of Care Investigation Tracker case and documentation archived in the restricted QOC Investigation folder for the member's case.

- The QI Coordinator will send a 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.

Related Policies:
CH-MCR-GA-01 Grievance and Appeals: Part C and D Grievances

Attachments:
Grievance team process for Quality of Care (QOC) Process
Quality Improvement QOC Investigation

New, Revised or Reviewed/ No Changes	Previous Policy Name, If Applicable/Description of Changes	Department Lead Approval (Name)	Date Department Lead Approved	Date Policy Committee Approved
New	NA	Julianne Eckert	10/1/2020	10/22/20