Definition: A grievance is any communication by an enrollee to GuildNet about dissatisfaction with the care and treatment received from GuildNet staff or providers of covered services, which does not amount to a change in scope, amount, duration of service or other actionable reason.

POLICY:

A member[1] or a provider on the member's behalf may make a grievance **verbally or in writing.** Members are advised of their right to file a grievance at the time of enrollment (and are advised of their rights and responsibilities annually). An explanation of the Grievance process is in the Member Handbook in the member's predominant languages (i.e., Spanish, Russian, English) and is available, as needed or requested, in alternate formats, such as audio and Braille. Members are advised as to how to file a grievance, and of their ability to get assistance from GuildNet staff, if necessary. All grievances will be resolved without disruption to the member's plan of care. Members will be free from coercion, discrimination or reprisal in response to a grievance.

All grievances, (both same day and non-same day resolution) are logged, tracked and reported. GuildNet will designate appropriate personnel, who were not involved in the previous level of decision-making to review grievances in supervisory capacity and on grievance appeal. If the grievance relates to clinical matters, the personnel assigned will include duly registered health professionals to process both grievances and grievance appeals.

Grievances (Non –same day resolution) are of two types: standard and expedited. **Standard** grievances, including both those reported verbally or written, are acknowledged **in writing** within 15 business days of receipt of grievance or less by the Quality Assurance Performance Improvement Department (QAPI) or Care Management Department. Grievances are addressed as quickly as required by the enrollee's condition. A standard determination is to be made within 45 calendar days of the receipt of all necessary information and no more than 60 calendar days from receipt of grievance. The standard grievance decision will be communicated by telephone and in writing within 3 business days of the decision. The review period for GuildNet's grievance determination can be increased by an additional 14 calendar days if it is in the enrollee's best interest. The member, the provider on the member's behalf or by GuildNet, may request the extension. The reason for the extension must be documented. When the extension is initiated by GuildNet, a notice will be sent to the member or the provider advising of the extension, the reason for the extension and specify how it is in the best interest of the enrollee. If a decision on the grievance is reached before the written acknowledgement

[1] Any reference in this policy and procedure to the member also includes anyone acting on the member's behalf including provider or vendor.

was sent, GuildNet will send the written acknowledgement with the grievance determination. A GuildNet decision to initiate an extension is made by senior staff, i.e., supervisors or directors, when it is established that inadequate information is available to make an informed decision.

If the standard response time to the grievance would seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function, GuildNet will **expedite** the grievance. The member or the provider may request that a grievance be expedited. **If GN agrees to expedite the grievance,** the expedited grievance determination will be made within 48 hours of receipt of all necessary information and no more than 7 calendar days from receipt of the grievance. **The expedited grievance decision will be communicated by telephone and in writing within 3 business days of the decision.**

If the expedited grievance decision is made before the written acknowledgement is sent, both the acknowledgement and expedited grievance decision will be combined If the member or the provider on the member's behalf, requests that the grievance be expedited and GuildNet does not agree, GuildNet will notify the member or the provider verbally within 2 days and in writing within 15 days, that the grievance decision was not expedited and the grievance will be handled within the standard grievance decision timeframes.

Grievance data and its analysis are to be used to identify opportunities for program improvement. GuildNet senior staff will review the grievance data from several perspectives, including provider type, specific providers, and GuildNet staff identified as responsible parties in the grievance.

PROCEDURE:

Overview

[The following procedures pertain to all services with the exception of Dental which is administered by HealthPlex and is described immediately following the internal procedures.]

The grievance process will be carried out by both the Case Management staff and the QAPI staff. Specifically, the Case Management Department with some exceptions, will receive the grievances, make the determinations and send out all necessary acknowledgements, notices and findings. The QAPI department will be responsible for monitoring the process for regulatory requirement, timeliness and accuracy. In addition, any priority grievances such as those received from the DOH hotline are to be directed to the QAPI Department. QAPI will log as priority and oversee processing by Case Management Department.

New grievances will be directed to the Care Management Department; either the Member Services Representative (MSR) (a non-clinical team member) or the Case Manager (a health care professional). Most enrollee calls are answered by the MSR

or, less frequently by a CM. If a grievance is received by an MSR, the MSR can resolve and log it if it is a **same day** resolution (a satisfactory outcome requiring no written acknowledgement or determination). If, however the grievance is received by the CM, or, it is too complex to be handled by the MSR, the CM will carry out all the steps as determined below with regard to logging acknowledgements, determinations and notices.

The Care Management responsibility for processing determinations of grievances will be overseen by a designated Case Management Supervisor. The Case Management Supervisor will on a daily basis supervise decision-making related to grievances and grievance appeals. This supervision will foster optimal clinical practice in the resolution of grievances and determinations. Professional expertise required for determinations will be identified and brought together by the designated Case Management Supervisor.

Grievances received by senior administration or other staff will be directed to the assigned QAPI staff who will in turn assign to the appropriate CM for processing. Problems identified, either in clinical practice or in the processing of grievances and grievance appeals by the QAPI staff, will be brought to the attention of the Case Management Supervisor for resolution. The content of the grievance and grievance appeals determinations are ultimately the responsibility of the designated Case Management Supervisor. Tracking for compliance with the grievance and grievance appeals process is the responsibility of the QAPI staff and reported to the QAPI Director.

The QAPI Director will be responsible for all internal management and external reports such as those to: the Case Management Supervisors and Directors, the administrative senior staff, the QA Advisory Committee, the GuildNet Board of Directors and the New York State Department of Health.

1) Grievances (same day and non-same day) may be verbal or written. The grievances may be resolved verbally at the time they are received or may take longer to investigate and remediate. The MSR or Case Manager receiving the grievance will log the grievance (other than denials and plan actions) which will include documentation of the following information:
    - Date and time grievance received;
    - The reporter of the grievance: (e.g., member, family, physican, NSDOH);
    - Name and ID number of the member;
    - Description and specifics of the grievance;
    - Person(s), service, and vendor involved in the grievance;
    - For same day resolution, the steps taken;
    - Name of staff member logging grievance;
    - Name of the Case Manager if different from the staff logging the grievance;

- The person, department, or vendor the grievance is referred to for follow up; and,
- Non same day resolution grievances /separate log
- Outcome of grievance resolution (i.e., whether substantiated or not substantiated).
- Whether expedited or standard, extensions taken and appeals were made and dates for all significant actions and notifications;

On a daily basis the Care Management staff will forward new grievances to the QAPI Director or designee. QAPI will identify unresolved grievances and forward those unresolved to the designated Case Management Supervisor for follow-up. Grievances (other than plan actions), which were not resolved the same day, will be acknowledged in writing, by the QAPI Specialist or Case Manager responsible. In addition to the log, grievance documentation in hard copy will be maintained by the QAPI Staff and will be reported to the New York State Department of Health, as required, on a quarterly basis.

Non-same day resolution grievances may be "Expedited" or "Standard".

2) GuildNet will decide at the time the grievance is received, if it is standard or **expedited** depending on the potential jeopardy to the member's life, health, or ability to attain, maintain or regain maximum function. Decisions to not expedite, i.e., when the plan allows a grievance to proceed as standard, are based on there being no jeopardy to the enrollee's health and when it is in the enrollee's best interest. The member, the provider, or GuildNet may initiate a request for a grievance to be expedited. If GuildNet does not agree to expedite a grievance, the member or the provider will be notified verbally in 48 hours and in writing in 15 days. Decisions that a grievance not be expedited are made by the designated Clinical Supervisor or Director. Expedited grievance determinations must be reviewed and approved by either senior administrative staff, the Medical Director or designee or the Case Management Director or designee. The results of the review are communicated to the member by telephone within 48 hours of receiving all necessary information and no more than 7 calendar days from receipt of the grievance. The QAPI staff will be responsible for grievance and grievance appeals oversight and timely determinations and notices. Expedited grievance acknowledgments and determinations will be combined into one notice, **communicated verbally within 2 days (48 hours) and in writing within 7 days.** Copies of all communications including acknowledgements and determinations will be maintained in the QAPI Department.

3) On **standard g**rievances an acknowledgement letter will be sent to the member, the member's representative and the provider (when appropriate) within fifteen (15) days of receipt of the grievance. The QAPI staff will send the acknowledgement letter identifying the staff assigned to review the grievance and will describe the review process and the member's right to grievance appeal. Copies of the grievance acknowledgement and grievance determination are maintained in the QAPI Department. Standard grievance decisions are made

within 45 calendar days of receipt of all necessary information and no more than 60 calendar days from receipt of grievance.

4) If the designated Case Management Supervisor or the QAPI Director decides that the review period needs to be increased in order to make an informed decision in the member's best interest, then the member will be notified in writing that an extension will be taken and the expected duration of the extension (up to the 14th day). In addition, the member or provider on the member's behalf, may also request an extension in writing or verbally. It is the responsibility of the designated Case Management Supervisor or the QAPI Director to send a letter to the member advising them of the extension and rationale for same and **how** the delay is in the member's best interest. Information and/or documentation to support the extension will be available for review by NYSDOH upon request at a later date as required.

5) The process of review can include:

   - Written summation of the overall nature of the grievance;
   - Contact with person who filed the grievance;
   - Review of the member's record;
   - If a vendor is identified in the grievance, a request may be made for a written response from the vendor that details the results of any investigation and outlines the steps to be taken if needed for a corrective action plan;
   - Conferences with the appropriate supervisory staff or Medical Director;
   - Review by outside clinical professionals; and,
   - Application of relevant assessment tools (i.e., "PCA Tasking Tool").

6) The QAPI staff or Case Manager sends a grievance determination letter to the member/representative within 45 calendar days of receipt of all necessary information and no more than 60 calendar days from receipt of the grievance. The letter will outline the nature of the grievance, the member information reviewed, any vendor response, and the data gathered that leads to the decision by GuildNet. The member is offered the option to appeal the grievance determination with the options for the grievance appeal process explained in the letter.

   Expedited grievance determinations are communicated to the member or provider by telephone within 48 hours of receiving all necessary information but not longer than 7 days from receipt of the expedited grievance. Expedited grievance acknowledgements and determinations will be combined in the same letter.

7) All grievance documentation is maintained by QAPI staff. Analysis of grievances by category and by vendor are performed and reviewed by the QAPI Director. All notices of acknowledgement, and determinations will be sent by mail. Receipts and copies of all communication will be stored in hard copy by QAPI in a central repository or electronically filed. The results of the grievance analysis are shared with senior staff, used to make business decisions, determine GuildNet's preferred

providers, educate staff/vendors, evaluate operational processes and implement corrective actions as needed.

8) The number and the description of all grievances are reported monthly to senior administrative staff and quarterly to the QAPI Committee. Provider Relations will contact vendors, as required, where performance problems are identified. Grievances will be considered in evaluating the provider's performance and in requesting corrective actions. The Provider Relations Department may take action, to suspend referrals, not renew the contract or terminate the contract for cause based on this information.

Dental

Dental services are managed under contract with HealthPlex. HealthPlex shall participate in and comply with GuildNet's **grievance** procedures and timeframes described above. HealthPlex shall maintain a written record, not limited to but including type of **grievance** and numbers of same, and provide such record monthly. At such time, HealthPlex will also provide all GuildNet specified relevant documentation regarding the **grievance** and shall provide any other applicable documentation in a timely manner as reasonably requested.

GuildNet will review periodically HealthPlex's compliance with GuildNet Policies and Procedures including such particulars as use of GuildNet letterhead for pertinent member correspondence and adherence to required timeframes.

Addendum: Plan for Information System

Currently all logging is done by MSR's and NCM's on an excel spreadsheet. Written guidance, supervision and QAPI Director provide the necessary prompts and directives for timeliness, acknowledgment and notices. It is the intention of GuildNet and The Guild Information and Technology staff to develop a management support Grievance and Grievance Appeals system.

The Grievance and grievance appeals logging, tracking and notification system will be used to respond to member grievances, New York State and Federal Regulations and continuous quality improvement efforts. The system will be designed to: require completeness in all enrollee identifiers; promote accuracy in event reporting; support best practice judgment in event responses and determination; and insure regulatory enrollee notification and timetables.

The central repository of information and the decision-directing core of the system will be the Log. A standardized set of enrollee and event identifiers appearing on the log will automatically populate all required notification forms insuring accuracy, completeness, and consistency throughout the process. The system will prompt the user following a decision tree and will not allow the user (care management or

QAPI staff) to escape the system until all required fields are completed. This insures completeness of the information and completion of enrollee verification requirements, if any. Additionally, to respond to the timed enrollee notification requirements, calendar driven prompts will appear on the user's and care management supervisor's screens when opened 3 days before the required date.

Internal and external management reports as described above will be generated by the system.