Healthfirst

OPERATING POLICY –

CompleteCare Complaint and Complaint Appeal for LTC benefits

Date of Initial Issue: **Date Last Reviewed:**

Classification

- ☐ NY Medicare
- ☐ NJ Medicare
- ☐ Corporate
- ☐ Family Health Plus
- ☐ NJ FamilyCare/Medicaid
- ☐ Child Health Plus
- ☐ PHSP Medicaid
- ☐ Commercial

I. Policy Overview

Healthfirst strives to achieve member satisfaction. When we become aware of any concerns or issues, we will try to resolve the concern as quickly as possible and to the satisfaction of our members. The complaint appeal process is available to all members who are not satisfied with decisions made by Healthfirst concerning a complaint.

II. Responsible Parties and Related Departments

Appeals and Grievance Department
Medical Management Department

III. Definitions

A **complaint** is any expression of dissatisfaction by the member, caregiver, or provider on the members' behalf, about care and treatment that does not amount to a change in scope, amount or duration of service.

IV. Policy

Healthfirst strives to achieve member satisfaction. When we become aware of any concerns or issues, we will try to resolve the concern as quickly as possible and to the satisfaction of our members. The complaint appeal process is available to all members who are not satisfied with decisions made by Healthfirst concerning a complaint.

A complaint can be verbal or in writing. Healthfirst will not require that members put complaints in writing. Healthfirst will designate one or more qualified personnel who were not involved in any previous level of review or decision-making to review the complaint and if the complaint pertains to clinical matters, the personnel must include licensed, certified or registered health care professionals.

Healthfirst will not retaliate or take any discriminatory action against a member because the member has filed a complaint or appeal. All information is kept confidential, per Healthfirst policy. Information will be shared only on a "need to know basis."

There will be no change in services or treatment provided by the plan or health care provider staff because a complaint or complaint appeal is filed. We will offer assistance to the member and/or

caregiver in filing a compliant or complaint appeal. This includes providing interpreter services, providing all correspondence in large type (14 point or more) and/or help for those with vision and/or hearing impairments. The member may choose someone (a relative, friend or a provider) to act on his or her behalf. For hearing or speech impaired, a Toll free number TTY 1-800-662-1220 is available.

PROCEDURE: Complaint Procedure

The Care Management Team may receive a complaint and attempts to resolve on the same day . If the CMT is unable to resolve the member's complaint to the member's satisfaction the same day, the complaint will be transferred to the Appeals and Grievance Department to be handled as a Standard Complaint. Most complaints will be resolved on the **same day** of receipt. However, if the staff member needs more time to investigate the issue or needs the assistance of other staff members or to communicate with external providers the complaint will be referred to the Appeals and Grievance Department.

Types of complaints include :

Same Day: Complaints that can be immediately rectified to the member's satisfaction on the **same day** do not require a formal written response. Same day complaints must be documented, logged and tracked for quality improvement and reporting purposes in our electronic tracking system.

Standard
A Same Day Complaint that is not resolved within 24 hours becomes a **Standard Complaint**.

Expedited Review: A member or the provider, on the member's behalf, may request an expedited review of a complaint if a delay in making a complaint decision would seriously jeopardize the enrollee's life, health or ability to maintain or regain maximum function. The complaint will be handled as expedited.

In the event that Healthfirst disagrees that the complaint resolution should be expedited, the Medical Director makes the determination regarding the member's request for an expedited review. Written notification will be sent to the member with the reason for the denial of his/her expedited request. The member will be informed that the complaint will be reviewed as a standard complaint.

Guidelines to follow in Resolving a Complaint

1. The following staff will be involved in resolving the Complaint
   - If the Complaint involves a clinical issue, a health care professional with appropriate clinical expertise will be involved in the resolution.
   - For non – clinical complaints, representatives of the Appeals and Grievance department along with representatives from appropriate department or discipline will be involved in the analysis and resolution of the complaint

2. Operational Procedures:
   - Staff member documents the ~~Grievance~~ Complaint in the management information system and takes appropriate action to investigate and/or resolve the issue.
   - The decision to treat the ~~Grievance~~ Complaint as an **Expedited Complaint** may be made in consultation with the Medical Director.
   - If additional information is needed to make a determination and to ensure timely and appropriate follow-up and documentation of ~~grievance~~ complaint and resolution, a letter is sent to the member acknowledging the ~~grievance~~ complaint and the response time (Standard or Expedited).

- The need for additional information will be determined based upon the details of the individual grievance and the best interests of the member.

Comment [KV1]: Do not need this?

- **Time Frames for Response - Standard Complaint**
- **Acknowledgment**: Within **15 business days** of receipt of the complaint. If additional information is required, this will be stated in the letter. If a decision is reached before written acknowledgement is sent, Healthfirst will include the written acknowledgement with the notice of the decision.
- **Resolution**: Resolution must be as fast as the member's condition requires but no more than **45 calendar days** after receipt of all necessary information and no more than 60 calendar days from receipt of the complaint.
- **Extension**: Review period can be extended **up to 14 calendar days.** Requesting an extension is typically in the best interests of the member to obtain relevant information to reach a satisfactory resolution. An extension may also be requested by the member or provider on the member's behalf (written or verbal). The opinions of other involved physician(s) and/or independent professionals may be sought to assist Healthfirst to reach an appropriate clinical decision. In all cases extension reasons must be well documented.
- A Supervisor and or Manager oversees the response and resolution of all complaints, including communication with relevant parties. Communication with the member is the responsibility of the Care Management Team.
- **Notification**: A written notice of the complaint decision within 3 business days of the decision which will include: the date of the complaint, the detailed reasons for the determination; in cases where the determination has a clinical basis, the clinical rationale for the determination; and the procedures for filing an appeal of the determination, including a form for filing such an appeal. The letter will include instructions for filing a Complaint Appeal (standard or expedited).

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3. Time Frame for Response - Expedited Complaint
   - **Expedited Complaint:** When a delay would seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function, or if a member or provider on a member's behalf requests an expedited review.
   - **Resolution**: A decision will be made as fast as the member's condition requires but no more than **48 hours** after receipt of all necessary information, and no more than 7 calendar days from receipt of the complaint. Healthfirst will honor and respond to complaints from members, or a provider on behalf of a member.
   - **Extension:** The review period can be extended **up to 14 calendar days**. The decision to seek extension is based upon the best interests of the member and the relevant facts and need for additional information to reach a satisfactory resolution. An extension may also be requested by the member or provider on the member's behalf. If initiated by Healthfirst, a written notice will be included in the expedited complaint extension letter to the member explaining the reason for the delay, how it is in their best interest and what information is needed and from whom.
   - **Notification***:* An acknowledgement letter is not required for an expedited complaint. The member will be notified of the decision by telephone within 1 business day and a written notice will be sent within 3 business days of the decision. The notice will include: the complaint, the detailed reasons for the determination; in cases where the determination has a clinical basis, the clinical rationale for the determination; and the procedures for filing an appeal of the determination, including a form for filing such an appeal. The letter will include instructions for filing a Complaint Appeal (standard or expedited).

Appealing a Complaint Determination

1. The member or his/her designee may not be satisfied with the decision we make regarding a complaint. They may request a second review of the issue by filing a **complaint appeal.**

2. Receipt of Complaint Appeal
   - The complaint appeal must be a written appeal. The complaint appeal may be submitted by letter or on the Healthfirst *Request for Complaint Appeal Letter*. If the member is unable to prepare a written request, the staff member will transcribe the oral request onto the Healthfirst *Request for Complaint Appeal Letter*. The request must be received within 60 business days after receipt of the Healthfirst notice of complaint decision. The date of the appeal request will determine all subsequent time frames.
   - Late requests for complaint appeals will be deemed ineligible and the member will be sent a letter indicating same.

3. Acknowledgment of Complaint Appeal:
   - Healthfirst will initiate a written complaint appeal acknowledgement letter within 15 business days of receipt of any request. If a decision is reached before the written acknowledgement is sent, Healthfirst will include the written acknowledgement with the notice of decision (one notice).
   - The acknowledgement will include the name, address and telephone number of the individual designated by Healthfirst to respond to the complaint appeal and what additional information, if any, must be provided in order for a decision to be rendered.
   - The member may request an expedited complaint appeal determination. If Healthfirst disagrees with a request for an expedited complaint appeal, Healthfirst will inform member of the denial to expedite in writing. Efforts will be made to contact the member by telephone to let them know that the complaint appeal will be handled as a standard complaint appeal.

4. Resolution of Complaint Appeal:
   - The determination of a complaint appeal on a ***clinical or non-clinical matter must*** be made by a qualified personnel at a higher level than the personnel who made the initial determination, and for clinical issues, the health care professionals will be someone who was not involved in the initial decision, at least one of whom must be a clinical peer reviewer.
   - During Healthfirst's review, the member can present additional information in writing. The member can also look at any of his/her records that are part of the appeal review.
   - Healthfirst will seek to resolve all complaint appeals in the most expeditious manner but no more than 2 business days after receipt of all necessary information (when a delay would significantly increase the risk to a member's health) or 30 business days after receipt of all necessary information in all other instances.

5. Notice of Complaint and Complaint Appeal Resolution:
   - The notice of complaint and complaint appeal resolution will include:
   - the complaint
   - decision made, and detailed reason for the determination
   - in cases where the determination has a clinical basis, the clinical rationale for the determination.
   - the title of the person(s) making the determination,
   - and the date the decision was reached.
   - For complaint resolutions, the instructions for filing a complaint appeal and the notice to the member of the right to contact the State Department of Health regarding his/her complaint including the state toll free number.

6. The Appeals and Grievance Department will maintain and secure written records

related to complaints and complaint appeals, investigation and written reports.

7. Complaint and Complaint appeal decisions will be tracked, analyzed and reported to the Heathcare Quality Council on a quarterly basis.

V. Sanctions

Violation of this policy will be considered in accordance with the corporate sanction policy.

VI. Approval Date/Signatures

Print Name	Signature/Title	Date
Print Name	Signature/Title	Date
Print Name	Signature/Title	Date
P&P Committee Approval - Print Name	Signature/Title	Date

VII. Procedures/Job Aids/Documents/Forms

VIII. Revision History: