Policy Title: Beneficiary Complaints, Grievances & Appeal Policy			
Department Responsible: THN Compliance & Integrity	**Policy Number:** OP-104	**THN's Effective Date:** January 1, 2022	**Next Review/Revision Date:** September 30, 2023
Title of Person Responsible: Director of Compliance & Privacy	**THN Approval Council:** THN Board of Managers	**Date Approved:** August 29, 2022	**Date Approved by THN Board of Managers:** August 29, 2022

I. PURPOSE. The purpose of OP-104 is to provide (1) a statement of Triad HealthCare Network's (THN's) policy regarding Beneficiary Complaints, Grievances and Appeals and, (2) procedures to ensure that THN's practices are consistent with its stated policies.

II. POLICY.

A. Service recovery and complaint resolution is a practice that demonstrates our commitment to caring for members (or members' families) whose expectations have not been met. The goal is for a THN employee to promptly turn an unmet expectation into a positive experience. We intend to restore our relationship with the member and/or family member and address all concerns in a member and family-centered approach. Our intent is to identify and recognize situations that may cause concern or complaint. This commitment to proactively addressing member needs increases the likelihood that we create positive experiences.

B. THN recognizes that members have the right to voice concerns without fear of discrimination or reprisal and to have these concerns reviewed and addressed in a timely manner. THN seeks to provide prompt review and timely resolution of complaints and grievances from members. The THN Board of Managers shall delegate resolution of complaints and grievances to THN management, THN Operations staff and/or the THN Director of Compliance & Privacy.

C. THN shall require its DC Participant Providers and Preferred Providers to make Medically Necessary Covered Services available to Beneficiaries in accordance with applicable laws, regulations, and guidance. Beneficiaries and their assignees retain their right to appeal claims determinations in accordance with 42 CFR Part 405, Subpart I.

D. All disputes brought by Beneficiaries regarding denied claims will be adjudicated under the claim's appeals process at 42 CFR Part 405, Subpart I.

E. Any change in State or Federal requirements will take precedence over this policy.

III. PROCEDURE.

A. **Members Informed of Procedure.** Members and/or their representatives are informed of their rights regarding complaints and grievances by the THN representatives receiving the complaints. If a member or their representative thinks their privacy has been violated or wants to complain to the Privacy Officer, they may call: 1-855-484-6669.

B. **Receipt of Complaint or Concern.**

1. Complaints are received directly by an appropriate staff member via the 24-hour nurse line and/or a member of leadership.
2. If the complaint involves allegations of abuse and/or neglect, staff should notify the appropriate authorities (e.g., APS, CPS, and police) immediately. The Social Services Department is available to assist staff if needed.
3. Responsibility for resolving complaints lies with the leadership of the department where the complaint occurs. Most complaints are resolved during a member visit by the employee who discovers the complaint. If the complaint is beyond the employee's scope of responsibility, the employee notifies department management for prompt resolution.
4. All THN staff seeks to provide prompt resolution of all member complaints by the "Take the LEAD Service Recovery Process" (**L** - Listen to concerns with **E** – Empathy, **A** – Apologize and acknowledge the concern, and **D** – Do something yourself or direct the concern to someone who can follow up).
5. The employee will immediately attempt to resolve and notify his/her supervisor and other appropriate leadership of any member complaint or concern that cannot be resolved. The "Take the LEAD Service Recovery Process" is used by the next level leader.
6. The Department Manager may consult with their immediate supervisor and/or the Office of Patient Experience concerning resolution of the complaint.
7. Risk Management is notified when the concern or complaint involves potential liability in connection with any complaint. This includes allegation of personal injury, property loss or damage, harassment, abuse, or threat of suit. If Risk Management takes the complaint, they handle it as a grievance according to the Member Grievance Resolution Process.
8. If the complaint alleges release of restricted information, the Privacy Officer is notified, and the complaint is moved to a grievance.

9. Upon receiving a complaint, the Department Director documents the information notifies the departments involved and takes appropriate corrective actions to resolve the complaint immediately.
10. Acknowledgement of receiving the complaint should occur within 24 hours. A resolution should occur promptly and by no more than seven days from receipt.
11. The Department Director documents the outcome and forwards the information to the Office of Patient Experience for tracking and improvement efforts.
12. If the complaint is about physician care by:
    i. *Cone Health providers:* The Vice President of Medical Staff Services is notified.
    ii. *Non-Cone Health providers:* For THN providers, reference the "Response to a Grievance" section below.
13. If the complaint cannot be resolved within the seven-day time span, the complaint evolves into a grievance.

C. **Examples of Member Grievances.**
1. All written complaints (received via fax, e-mail, US mail, interoffice mail, social media, or attached to a survey) regarding member care, abuse, and neglect or Conditions of Participation (COP) compliance.
2. A verbal complaint regarding member care from a member or member's representative that cannot be resolved and is either delayed, referred, requires more investigation, or requires further action for resolution.
3. All verbal allegations of abuse, neglect, member harm, release of restricted information, or noncompliance with the COP.
4. A complaint that was unresolved during the member inpatient stay that is identified during a transition of care call. A completed member satisfaction survey (on which the member specifically requests resolution in the comments). If a written complaint is attached to a survey, it must be treated as a grievance.
5. All post-visit complaints to the Office of Patient Experience, the THN website, social media platforms, or THN leadership.
6. Billing issues are not usually considered grievances. However, a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR §489 is considered a grievance.

D. **Receipt of Grievance.** Responsibility for the grievance management process lies with the Office of Patient Experience in coordination with the Leadership Alliance member responsible for the area where the grievance occurred.

E. **Response to a Grievance.**
1. All grievances are forwarded to the Office of Patient Experience and/or Medicare Advantage plan*.

2. The Office of Patient Experience and Medicare Advantage plan ensures the process and timing of the grievance procedure is followed.
3. If a member or legal representative calls the Office of Patient Experience after regular hours to submit a grievance, the caller will be informed that urgent concerns or requests should be referred to the administrative coordinator by calling the switchboard operator. If the urgency of the concern or grievance warrants, the administrator-on-call may be consulted.
4. Within seven calendar days, the member or legal representative will be contacted by the Office of Patient Experience to address resolution or notify the member or representative that further investigation is required. The member will be informed of an expected follow-up time to address the resolution and will be kept informed of the progress on a weekly basis. All grievances will be resolved as soon as possible, with a goal of resolution within seven calendar days and the requirement that it takes no longer than 30 days.
5. Risk Management is notified when the concern or complaint involves potential liability in connection with any complaint. This includes allegation of personal injury, property loss or damage, harassment, abuse, or threat of suit. The Office of Patient Experience will close the grievance at that time.
6. If the grievance alleges release of restricted information, the Privacy Officer is notified, and the investigation is handled by the Privacy Officer. The Office of Patient Experience will close the grievance at that time.
7. At the conclusion of the grievance review, the Office of Patient Experience will send written correspondence to the member or legal representative including Cone Health contact person, title, phone number, steps taken in the investigation, finding, and date investigation was completed.
8. The grievance is considered resolved when the member or representative is satisfied with the actions taken. If the member or representative is dissatisfied, the grievance is considered resolved when the facility has taken all appropriate and reasonable actions on behalf of the member.
9. Electronic copies of member letters are maintained in the Office of Patient Experience for the grievance log and/or THN's Compliance Log.

F. **Appeals.** If the member or representative is not satisfied with the response to the grievance, the Operations Department Representative will notify him or her of the appeals process.

1. The member or representative is required to provide a written statement requesting an appeal of the grievance that includes why he/she is not satisfied.
2. The appeal is reviewed by the Director of Operations or the Director of Compliance.
3. A letter is sent to the member or representative within thirty (30) business days indicating whether the grievance resolution is supported or overturned. If the appeal is upheld the beneficiary will be directed to call 1-800-Medicare for further guidance.

Date	Reviewed	Revised	Notes
January 1, 2022			Original Publication
August 2022	X		No changes