Chapter 9

Clinic Complaint Reporting Process

Overview

Member complaints are highly regulated by federal and state agencies. The Minnesota Department of Health requires each health plan to conduct ongoing evaluation of all their member complaints, including Quality of Care (QOC) grievances received and investigated by contracted providers (Minnesota Rule 4685.1110 Subpart 9 (A)). Member grievances directed to the contracted provider should be investigated and resolved by the contracted provider.

The Minnesota Department of Health (Minnesota Statute 62D.123, Subd 2) requires contracted providers to comply with South Country Health Alliance's (South Country's) dispute resolution process. Contracted providers are required to report South Country member QOC complaints data that originates at the provider level to South Country on a quarterly basis (Minnesota Rule 4685.1110 Subpart 9(C)).

This chapter outlines important procedures and responsibilities regarding South Country member complaints that are received and handled by the contracted provider.

This process applies to all South Country programs. Failure to comply with this reporting process may be considered a breach in contractual responsibilities.

Please see Chapters 13 and 14 for information on South Country's grievance system, which includes QOC complaints.

Definitions

Grievance: An expression of dissatisfaction about any matter other than an action, including but not limited to the quality of care or services provided or failure to respect the member's rights. (A QOC grievance may include allegations that appropriate care was not provided, care was not given in an appropriate setting or the care did not meet professionally recognized standards of care).

Quality of care grievance: (as defined in the CMS Manual titled, "Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance" (effective August 3, 2022)) A grievance 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.

Quality of care grievance (as defined in MN Statute 62D.115 Subd. 1): An expressed dissatisfaction regarding health care services resulting in potential or actual harm to an enrollee. Quality of care complaints may include the following, to the extent that they affect the clinical quality of health care services rendered: access; provider and staff competence; clinical appropriateness of care; communications; behavior; facility and environmental considerations; and other factors that could impact the quality of health care services.

Action: 1) the denial or limited authorization of a requested service, including decisions based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit, 2) the reduction, suspension, or termination of a previously authorized service; 3) the denial, in whole or in part of payment for a service; 4) the failure to provide services in a timely manner; 5) the failure of the MCO to act within the timeframes defined in Article 8 regarding the standard resolution of grievances and appeals; 6) denial of an

Enrollee's request to dispute a financial liability, including cost sharing, or, 7) for a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right to obtain services outside the network. Action means the same as "adverse benefit determination" in 42 CFR §438.400(b).

Medicaid (MN DHS) Grievance Categories and Examples:

- **Access:** Inability to obtain referrals, delays in obtaining service, delays in appointment scheduling, excessive wait times, inability to obtain medical information, lack of availability of special services or inadequate geographic options.
- **Communication/Behavior:** Rude/uncaring/disrespectful, rushed/didn't listen/inadequate amount of time spent, inadequate education/failure to provide complete explanation, delay in communicating test results or inappropriate behavior/culturally insensitive/inadequate privacy. This category is used for complaints against provider staff who are not employed with South Country (this includes clinic staff, transportation drivers and home care staff).
- **Coordination of Care:** Failure to follow-up, information not provided/available at time of care, multiple providers/lack of overall coordination of treatment, treatment delay due to lack of communication between providers or delay in a referral.
- **Facilities/Environment:** Facility does not physically accommodate patient needs, uncomfortable environment, equipment malfunctions, cleanliness/infection control procedures, unsafe physical conditions, and provider clinic/administrative issues, business practice and process at the clinic level.
- **MCO (Managed Care Organization) Administration:** Complaints about member materials, ID cards, benefit set dissatisfaction, MCO member process issues, non-appealable claims or billing process issues (i.e. provider charging too much for service).
- **Technical Competence/Appropriateness:** Inappropriate treatment, delayed or incorrect diagnosis, wrong test ordered or performed, procedural error, performing procedure/service outside scope of practice/expertise or failure to refer.
- **Provider Balance Billing**

Process

South Country Responsibility:

1. South Country will provide a means for the contracted provider to submit quarterly QOC member grievance data (e.g., a grievance log/form that can be submitted via fax or other agreed upon method).
2. South Country will review the complaint data and provide any necessary follow-up with the provider. This review will be conducted by key South Country departmental staff, and may include the grievance & appeals manager, associate director of provider network and contracting and the medical director.
3. South Country will monitor contracted provider compliance with this process.

Contracted Provider Responsibility:

1. Designate a person with appropriate skills and authority to be responsible for handling and resolving member grievances.
2. Have internal complaint policies and procedures that outline the provider's process for receipt, documentation, investigation, and resolution of grievances. In addition, the

contracted provider will have a system to review grievance trends for consideration of necessary quality improvement activities.

3. For each member grievance, ensure a thorough investigation, appropriate resolution and timely completion. You may refer to Chapter 14 to reference regulatory timeframes followed by South Country when a member grievance is filed directly with the health plan.
4. If the member is not satisfied with the outcome or resolution, they should be given options for further consideration of the complaint. The member can be directed to:
    1. Call South Country Member Services, Monday – Friday from 8:00 A.M. – 8:00 P.M. (April through September) and from 8 a.m. to 8 p.m., 7 days a week (October - March) at 1-866-567-7242 (toll-free) (TTY 1-800-627-3529 or 711)
    2. Or contact other resources such as:

        Minnesota Department of Health
        Managed Care Section
        PO Box 64882
        St. Paul, MN 55164-0882
        Telephone: 651-201-5100 (Twin Cities metro) or 1-800-657-3916 (toll free greater Minnesota) (TTY 711)

        Fax: 1-651-201-5186

        Or

        Minnesota Department of Human Services
        The Office of Ombudsperson for Public Managed Health Care Programs
        PO Box 64249
        St. Paul, MN 55164-0249
        Telephone: 651-431-2660 (Twin Cities metro) or 1-800-657-3729 (toll free greater Minnesota) (TTY 711)

        Fax: 1-651-431-7472
5. Log all QOC complaints from South Country members on the Quality Complaint Reporting form. If another form or electronic tracking system is used, the report must include:

- Grievance receipt date;
- Facility location;
- Member first and last name;
- Member date of birth;
- Member allegation (please note the specific allegation; enough detail must be provided for South Country to clearly understand the nature of the complaint);
- Outcome/findings/recommendations; and
- Summary of resolution and any corrective action steps taken.

Submit the Quality Complaint Report no later than 30 days after the end of each quarter to the South Country grievance and appeals department. The report can be mailed or faxed to:

South Country Health Alliance
Grievance and Appeals Department
6380 West Frontage Road

Medford, MN 55049
Fax: 507-444-7774

If you have zero QOC complaints for the reporting quarter, you will NOT be required to submit a Quality Complaint Report form.

You may call South Country (507-444-7770 (Main Office) or 1-866-567-7242 (Member Services)) and request to speak to South Country's Grievance & Appeals Manager for any questions regarding this process.