EVOLENT HEALTH LLC
POLICY AND PROCEDURE

POLICY TITLE:	**Ongoing Monitoring of Sanctions, Complaints and Quality Issues**
DEPARTMENT:	**Provider Credentialing**
ORIGINAL DATE:	**February 2016**

Approver(s): Sharlee LeBleu, Director, Credentialing Operations

Policy Review Committee Approval Date: May 30, 2019

Product Applicability: mark all applicable products below:

COMMERCIAL	[ ] HMO	[ ] PPO	*Products:* [ ] Small [ ] Indiv. [ ] Large	*Exchange:* [ ] Shop [ ] Indiv.	[ ] All
	States: [ ] GA [ ] MD [ ] OH [ ] TX [ ] _________				
GOVERNMENT PROGRAMS	[ ] MA HMO [ ] MA C-SNP [x] MA D-SNP [ ] MSSP [ ] Next Gen ACO [ ] MA All				
	[x] Medicaid *States:* [ ] DC [x] KY [ ] MD [ ] _______				
OTHER	[ ] Self-funded/ASO				

Regulatory Requirements: Medicare Managed Care Manual Chapter 6 Section 60, 42 CFR §422.222, 42 CFR §422.503, 42 CFR §438.808, Medicaid Managed Care Contract with the Commonwealth of Kentucky Department for Medicaid Services Sections 28.2, 29.3 and Appendix J, 907 KAR 17:015, and National Committee for Quality Assurance (NCQA) CR.6

Related Documents:
NVR.010.E.KY Practitioner Credentialing and Recredentialing
NVR.012.E.KY Organizational Provider Credentialing and Recredentialing
NVR.014.E.KY Practitioner Sanctioning and Reporting
NVR.019.E.KY Aperture Credentialing LLC Primary Source Verification and Provider Enrollment
NVR.021.E.KY Responsibilities of the Chief Medical Officer or designated Medical Director and the Credentialing Committee
QI.026.E.KY Quality of Care Review for Member Concerns
QI.027.E.KY Practitioner Office-Site Visits Related to Member Complaints
QI.025.E.KY Quality of Care Review for Sentinel Events
PHP-PR-52.0 Member Complaints and Inquiries for Immediate Investigation by Provider Network Management
PHP-PR- 57.0 Provider Office Site Visit
QI.033.E.KY Medical Record Standards and Review

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PURPOSE

The purpose of this policy is to provide guidance for the process of monitoring sanctions, complaints and quality issues that could affect the health and safety of our members. Profiling patient complaints and using those results helps promote patient safety and reduce risk for the Health Plan.

DEFINITIONS

Adverse Occurrences: Clinical symptoms or courses of treatment that are out of the ordinary and places the member at risk for potential harm. Adverse Occurrences are events that do not fit the definition for sentinel events but requires additional investigation.

Aperture Credentialing, Inc.: Credentialing Verification Organization delegated to perform Primary Source Verification Credentialing Services. Aperture Credentialing, Inc., as well as Ongoing Monitoring of Sanction services. Aperture queries System of Award Management (SAM) at each credentialing and recredentialing event and on a monthly basis.

Credentialing: Review and evaluation of the qualifications of licensed independent practitioners to provide services to its members. Network approval is determined by the extent to which applicants meet defined requirements for education, licensure, professional standing, service availability, and accessibility, as well as, for conformity to the utilization and quality improvement requirements.

Medical Record Review Audit: An annual review and evaluation of provider records to determine compliance with medical record keeping standards as determined by the National Committee for Quality Assurance (NCQA) and the Department of Medicaid Service (DMS). Member Concerns: (QOC) concerns/complaints initiated by members and/or member advocates.

Provider office site visit: An on-site office visit conducted to assess the quality, safety and accessibility of office sites where care is delivered.

Recredentialing: Evaluation of performance monitoring data and review of the credentialing information that is subject to change over time.

Sanctions: An adverse action taken against a practitioner's participating status for a serious deviation from, or repeated non-compliance with, quality standards, deviations from recognized treatment patterns of the organized medical community, and/or action or conduct of the practitioner which affects or could affect adversely the health or welfare of a patient.

Sentinel Event: As defined by the Joint Commission, a sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Death is not related to the natural course of the patient's illness or underlying condition. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response. It is important to note that the terms "sentinel event" and "medical

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error" are not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events.

POLICY

It is the policy of Evolent Health to monitor on an ongoing basis for information of providers regarding:

- Medicare and Medicaid sanctions
- Sanctions or limitations on licensure
- Provider-specific complaints
- Quality of care issues, including but not limited to:
  - Sentinel/Adverse events
  - Clinical member concerns
  - Medical record review non-compliance
- Federal debarment/suspension list

When a sanction, debarment, provider-specific complaint or quality of care issue is identified, follow-up actions/interventions as deemed appropriate will be taken, including but not limited to the following:

- No additional action required
- Provider education
- Referred to a Health Plan Medical Director and Credentialing Peer Review Committee for review and appropriate action.

A. Review of Medicare and Medicaid Sanctions and Limitations on Licensure

1. Evolent conducts monthly monitoring of all providers in the provider database including participating and non-participating entities on an ongoing basis for possible sanctions or disciplinary actions, possible Medicare or Medicaid sanctions/exclusions or reinstatements, or adverse action taken by the state medical licensing and/or applicable allied health boards or the Department of Health & Human Services Office of the Inspector General.
2. Evolent queries SAM on a monthly basis. Information may also come to Evolent from Client/Health Plan Regulatory Affairs, Compliance or Program Integrity department.
3. Aperture Credentialing, Inc., also provides a monthly sanctions report for all providers loaded in their system.
4. Upon notification of any sanctions or limitations on licensure for one of the practitioners, the provider credentialing department immediately prepares the file for review at the Client Health Plan's next scheduled Credentialing Peer Review Committee. If the sanction is such that it is a violation of the contract, i.e. revoked or suspended license, the practitioner may be terminated for failure to meet minimum contract requirements without review and approval by the Client Health Plan's Credentialing Peer Review Committee.
5. For sanctions on non-participating providers, Evolent will terminate the provider's non-participating status. The provider credentialing department prepares a

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summary of events and action taken by Evolent for review at the next scheduled health plan client Credentialing Peer Review Committee.

B. Complaints and Grievances

1. On a continuous basis, Evolent Health investigates all provider-specific complaints documenting the details of the complaint into the case file within the Complaint and Grievance database.
2. Follow-up and appropriate actions on complaints are performed and responded to within 30 calendar days of the receipt of the complaint, by the following departments as deemed necessary:
   - The Provider Network Management and Quality Improvement Departments, reviews, follows up and documents complaints regarding patient access or the office site. Appropriate actions are completed as deemed necessary.
   - The Quality Improvement (QI) Department reviews, follows up and documents complaints affecting patient care and office sites if it is a safety or environmental concern. A thorough investigation and follow-up is completed and appropriate actions are implemented as deemed necessary.
3. All details and follow-up actions of the complaint investigations are forwarded to Evolent's Credentialing Department for inclusion in the provider's credentialing file. This information is reviewed by the Credentialing Peer Review Committee at recredentialing.
4. At the time of recredentialing, the credentialing staff queries the Complaint and Grievance database for provider-specific complaint(s). All provider specific complaints are filed in the provider's credentialing file for review by the Credentialing Peer Review Committee.
5. Monitoring of Complaint Trends: Evolent Health in collaboration with Quality Improvement, Member Services and Provider Network Management Departments, monitors and tracks provider-specific complaints for trends/thresholds on an ongoing basis.
   - Each department documents all complaints onto a tracking grid that is located on a Health Plan Secure Share Point site.
   - Each department, in accordance with their department policy and procedure, with indicate on the tracking grid, if the provider met or did not meet threshold, category of complaint and if the complaint is referred for Credentialing/Peer Review Committee in-between credentialing cycle review or for next cred cycle review.
   - Providers for whom the complaint threshold is met is presented to the Credentialing Peer Review Committee for an in-between credentialing cycle review.
6. The history of complaints for all practitioners are evaluated by Evolent Health at least every six months.

C. Quality of Care Issues

1. **Review at Recredentialing:** The Health Plan Quality Improvement Department forwards to the Credentialing Department, a copy of the final report summarizing

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the case and provider communications with follow-up action(s) of any identified provider quality concern or adverse event. The report will be filed in the provider's credentialing file and will be reviewed by the Credentialing Peer Review Committee at recredentialing.

2. **Monitoring of Quality of Care Trends:** The Health Plan QI Department continuously monitors and tracks provider quality of care issues to identify trends and reports such trends to the Evolent Credentialing Department. The Quality of Care (QOC) case information is included in the provider's credentialing file for review at recredentialing.

D. Committee Actions

For sanctions or limitations taken against licensure, trends in member complaints or quality adverse events/sentinel events, the Health Plan's Credentialing Peer Review Committee reviews and makes determinations regarding provider's participation status in the client Health Plan provider network. When instances of poor-quality are identified, the Health Plan implements appropriate interventions in accordance with NVR.010.E.KY Practitioner Credentialing & Recredentialing or NVR.012.E.KY Organizational Provider Credentialing & Recredentialing.

E. Loss of Medicare and/or Medicaid Participation

In the event, Evolent receives a notification originating from the state that a provider has been excluded from Medicare or Medicaid participation, the credentialing department will request immediate termination from the client Health Plan's network Medicare and/or Medicaid provider network.

RECORD RETENTION

Records Retention for Evolent Health documents, regardless of medium, are provided within the Evolent Health records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.

REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE REVISED
New Policy	12/2016
Added Procedure III- Loss of Medicaid Participation language; revised to ensure responsibilities of parties is clear	06/2017
Significant changes necessary to align all complaints against providers coming in from various departments. Policy also has a change of ownership.	05/2018
- Annual Review & Structural Adoption - Change of Policy Ownership from Joel Scott to Sharlee LeBleu	05/30/2019

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