PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: CGA024</td><td colspan="3">Lead Department: Administration
Business Unit: Grievance & Appeals</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Medi-Cal Member Grievance System</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 02/11/99 (MS 300)</td><td colspan="4">Next Review Date: 02/12/2026
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I. RELATED POLICIES:

A. MCND9002 Cultural & Linguistic Program Description
B. MPQP1016 Potential Quality Issue Investigation and Resolution
C. MCUP3037 Appeals of Utilization Management/Pharmacy Decisions
D. MPQP1022 Site Review Requirements and Guidelines
E. CGA022 Member Discrimination Grievance Procedure

II. IMPACTED DEPTS:

A. Member Services
B. Provider Relations
C. Health Services

III. DEFINITIONS:

A. Acknowledgment Letter is a written notification of receipt of a grievance or appeal that is sent to themember or the member's authorized representative.
B. Adverse Benefit Determination encompasses all previously existing elements of "Action" under federal regulations with the addition of language that clarifies the inclusion of determination involving medical necessity, appropriateness, setting, covered benefits, and/or financial liability. An adverse benefit determination is defined to mean any of the following actions taken by a Managed Care Plan (MCP) (i.e., Partnership HealthPlan of California (Partnership)):
    1. The denial or limited authorization of a requested service, including determinations based on thetype or level of service, medical necessity, appropriateness, setting, or effectiveness of a coveredbenefit.
    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 to act within the required timeframes for standard resolution of grievances and appeals.
    6. The denial of the member's request to obtain services outside thenetwork.
    7. The denial of a member's request to dispute financial liability.

[1] This policy may also apply in part to Partnership Advantage, the HealthPlan's Medicare product effective Jan. 1, 2026 in eight counties: Del Norte, Humboldt, Mendocino, Lake, Marin, Sonoma, Napa, and Solano, and may be subject to change based on Centers for Medicare and Medicaid Services (CMS) rules.

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C. Appeal is a member's request to Partnership for reconsideration of an adverse benefit determination resulting in the delay, modification, or denial of a service, benefit or claim based on medical necessity, or a determination that the requested service was not a covered benefit.
D. Authorized Representative is a relative, friend, attorney or other person authorized by the member to represent them in matters regarding their healthcare.

E. Complaint is the same as a grievance. See grievance definition.
F. Deemed Exhaustion occurs if Partnership fails to adhere to the state and federal notice and timeframe requirements for either a Notice of Action (NOA) or a Notice of Appeal Resolution (NAR), including failure to provide a fully translated notice, or failure to provide timely and/or sufficient notice in the member's alternative format preferences. When deemed exhaustion occurs, the member may bypass Partnership's internal appeal process and initiate a state hearing.
G. Disputed Services means covered services that are the subject of a pending appeal or state hearing due to an adverse benefit determination by Partnership, or its subcontractors, to terminate, suspend, or reduce previously authorized covered services.
H. Expedited Review is the process by which a decision is rendered when a grievance involves an imminentand serious threat to the health of the member, including, but not limited to: severe pain, potential loss oflife, limb or major bodily function. Expedited reviews are approved by physician reviewers. An expedited review is also acknowledged verbally, whenever possible.
I. Grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination.
    1. Exempt Grievance is a grievance that is resolved by the end of the following business day. These grievances are handled by the Member Services Representatives or Grievance staff and are receivedover the telephone. These grievances are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment.
    2. Standard Grievance is a grievance that cannot be resolved by the end of the following business day.These grievances are handled by the designated Grievance staff.
J. Grievance Nurse Specialist (GNS) is the clinical staff member responsible for initiating and coordinating a multi-disciplinary team approach to handling of grievances with members, providers, plan Medical Directors, departmental directors and managers and others to evaluate, monitor and assure that medically necessary services are provided in a quality, efficient and timely manner. Clinical support is provided to non-clinical staff as needed. The GNS may also provide input or participate in state hearings.
K. Grievance Case Analyst (GCA) is the staff member who is responsible for summarizing, analyzing, investigating and issuing acknowledgments and resolutions to member

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grievances and appeals. The GCA also represents Partnership during state hearings.

L. Grievance system is the computer system that Partnership uses to log and track member grievances, appeals,and state hearing requests, which are logged by specific grievance types.

M. Inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries mayinclude, but are not limited to; questions pertaining to eligibility, benefits, or other Partnership processes. Where Partnership is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

N. Member is the Medi-Cal eligible individual receiving health care through Partnership to whom reference willbe made as "member" in all protocols.

O. Member Grievance Review Committee (MGRC) is a forum to conduct multidisciplinary review of member grievances (grievances and all level appeals). The committee is made up of representativesfrom Grievance & Appeals, Member Services, Provider Relations, Care Coordination, Quality Improvement, Utilization Management, and Compliance.

P. Member Services Representatives (MSRs) are the Partnership staff members who assist members or their authorized representatives in learning about and understanding the services and benefits offered through Partnership, including the grievance, appeal and state hearing procedures, and assist members in obtaining resolution to their issues.

Q. Non-Contracting Provider or Practitioner is a health care provider who does not have a contract with Partnership, but may do business with Partnership for specific reasons, e.g., provision of emergency, out-of-state area or one-time member care.

R. Notice of Action is a formal letter informing a member of an adverse benefit determination.

S. Practitioner is a licensed individual who provides medical care.

T. Primary Care Provider (PCP) is a physician who has executed an agreement with Partnership to provide theservices of a primary care physician.

U. Provider is an organization such as a hospital, residential treatment center or rehabilitation facility.

V. Resolution Letter is written notice of the outcome of a grievance or an appeal. This letter will includeinformation regarding any applicable next steps and appeal rights.

W. State Hearing is an appeal filed with the California Department of Social Services. The case is presented to an Administrative Law Judge (ALJ).

IV. ATTACHMENTS:

A. Your Rights Under Medi-Cal Managed Care Letter

B. Member Grievance Form

V. PURPOSE:

To ensure the thorough, appropriate, and timely resolution to member grievances, appeals, and state hearingrequests as well as to ensure Partnership's responsiveness to issues raised by

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Partnership members. The sections below outline the various components to the Grievance System as well as the process for each type of grievance. This policy is written in accordance with Partnership's contract with the Department of Health Care Services (DHCS) Exhibit A, Attachment 13, 14, All Plan Letter 21-011, Title 28 §1300.68 [except Subdivision §1300.68(c) g) and (h)], §1300.68.01[except Subdivision §1300.68.01(b) and (c)], Title 22 §53858, 42 CFR438.420(a)(b) and (c) and 42 CFR 438.406(b)(3).

VI. POLICY/PROCEDURE:

A. Member Rights

Partnership takes member grievances, appeals and state hearings seriously and strives to reach a fair resolutionafter a thorough evaluation of each issue. Partnership will address all grievances, appeals and state hearings in a timely and efficient manner and ensure that members are given reasonable opportunity to present evidence, facts, and laws in support of their grievance. This evidence can be provided in writing, in person, or by telephone. Members have the right to file a grievance or appeal regarding Partnership services. Our benefits and services are described in Partnership's Member Handbook, and include but are not limited to, the following:

1. Medical Services
2. Durable Medical Equipment (DME)
3. Vision Services
4. Transportation
5. Enhanced Care Management (ECM)
6. Community Supports (CS)

The objectives of the grievance resolution process are as follows:

1. To protect the rights of members.
2. To ensure that there is no discrimination by Partnership against a member on the grounds that the memberfiled a grievance, appeal or state hearing.
3. To provide orderly and prompt responses.
4. To assist members in accessing medically necessary care on a timely basis.
5. To facilitate the investigation and resolution of medically related issues by the Medical Director andHealth Services staff.
6. Submissions of a grievance are not construed as a waiver of the member's right to request a statehearing related to an adverse benefit determination.
7. To report and evaluate aggregate data on member grievances to determine areas requiring corrective action and/or opportunities for improvement. To develop and implement necessarycorrective actions with the intent of achieving increased member satisfaction.
8. To ensure that all members have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to; translation of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters,telephone relay

systems and other devices that aid disabled individuals to communicate.

9. Ensure members are advised of their rights to submit evidence, facts and law in support of theirgrievance and are given 10 calendar days to submit the documentation.

B. Cultural and Linguistic Requirements

1. At any point during the grievance process, a member has the right to language translation, including for all Partnership threshold languages and other non-English languages consistent with Partnership policy MCND9002 Cultural & Linguistic Program Description. This includes standard documents and correspondence. The procedure for review of member grievances ensures that all grievances are reviewed by GCAs for any cultural and linguistic issues. Training is provided on a yearly basis.
   a. Consistent with APL 21-004, Partnership advises members of its nondiscrimination policy and availability of language assistance services by providing detailed enclosures with all grievances and appeals related member notices. The Nondiscrimination Notice is also available, upon request, in all threshold languages.
   b. Consistent with APL 22-002, Partnership will provide appropriate auxiliary aids and services to members with disabilities, including alternative formats, upon requests.

C. How grievance processes are communicated to Partnership members

Members will be advised of their rights and access to grievance processes by the following means:

1. Written Materials – The Partnership member grievance process explaining how to file a grievance isprinted in the Partnership Evidence of Coverage/Disclosure Form. It is included in the Partnership MemberNewsletter at least once each year, mailed with all grievance and appeal acknowledgment andresolution letters and on notifications of all treatment authorization request (TAR) denials.
2. Oral Communication – Telephone calls with Partnership staff and Partnership providers and/or practitioners.
3. Contracting Provider – Member grievance forms and a description of the grievance process isavailable at each contracting provider's office.
4. Partnership Website – Partnership maintains a website on the internet, which provides member grievance forms and information to members on how to file a grievance with Partnership and the expedited medical reviewprocess.
5. Items 1, 3 & 4 above all include the toll-free phone number, internet address, physical addresses, and the toll-free phone number for the hearing and speech impaired for Partnership.

D. Member Grievance Process

Grievances may be filed at any time following any incident or action that is the subject of the member'sdissatisfaction. Grievances may address, but are not limited to, the following issues:

1. Difficulty obtaining an appointment
2. Customer service at the provider or practitioner office
3. Billing issues
4. Appointment waiting times

5. Facility conditions
6. Confidentiality issues
7. Refusals of PCP to refer the member for care

E. Grievances Filed

Members can receive assistance in filing a grievance or appeal from a patient advocate, a provider filing on behalf of the member, an ombudsperson or any other persons chosen by the member. There are five (5) methods members or a member's authorized representative may use to file a grievance:

1. By Telephone
   The member can contact Partnership's Member Services department to file a verbal grievance. Partnership usesboth bilingual staff and interpreter services for members who speak other languages (in accordancewith Title 22 CCR 53858). An MSR will record the grievance into Partnership's grievance system.
2. In Writing
   The member may also submit their grievance in writing to Partnership. Upon request, members can request a member grievance form from Partnership or from a contracted provider office. The member grievance form contains information regarding the Partnership member grievance system. Anauthorized representative form is available upon request.
3. In Person
   Members may also visit Partnership's offices in Eureka, Fairfield, and Redding to request an in-person meeting with an MSR to express their grievance in person. Members can also request assistance in filing a grievance from the MSR or Grievance staff. If the member is under the age of 18, a parent or guardian may file a grievance on their behalf. Members may also fill out an AuthorizedRepresentative Form to authorize someone of their choice to represent them.
4. Contracted Provider
   Members may file a grievance at one of Partnership's contracting providers' offices. The form titled "Member Grievance Form" is available at all contracted provider offices (in accordance with Title22 CCR 53858).
5. Partnership website
   Members can file a grievance by visiting Partnership's website at: http://www.partnershiphp.org/Members/Medi-Cal/Pages/Complaint,-Appeal-and-Hearing.aspxh andselect "Online Grievance Form" to file their grievance electronically through Partnership's secure server. Members can contact Member Services for help navigating the website.

F. Delegation

1. Partnership delegates the grievance process, or portions thereof, to Carelon Behavioral Health with the exception of Substance Use Disorder (SUD) related grievances

pertaining to the Drug Medi-Cal Organized Delivery System (DMC-ODS).

2. Partnership oversees the delegation of the grievance process conducted by these entities through quarterlyreviews of the grievance logs and annual audits.
3. Partnership requires corrective action plans whenever Partnership designated staff identifies a problem in any ofthese entity's processes and assigns a deadline for receiving evidence that the problem has been resolved.
4. Partnership provides our Grievance & Appeal policies and procedures to subcontractors/delegates and downstream subcontractors/delegates at the time that they enter into a subcontractor agreement. The policy is available via Partnership's Provider Manual, which is accessible via our external website, https://www.partnershiphp.org.

G. Resolving Member Grievances

The steps to resolve a member's grievance will occur as outlined below, which is established by the date Partnership receives the grievance.

1. The following documents are sent to the member by the grievance staff within five (5) calendar daysof receipt of the member's grievance:
   a. Acknowledgment Letter- acknowledges the date the grievance was received and the name,address and phone number of the GCA who may be contacted about the grievance or the appeal and the toll-free phone number for hearing and speech impaired members.
2. The GCA will conduct a preliminary investigation by contacting medical staff, Partnership's medical staff or other appropriate individuals to gather information.
   a. If the grievance is about quality of care, diagnosis or treatment, or other medical quality issues,the GCA will consult with the GNS.
   b. As noted in section I and J, below, the GNS classifies each grievance as clinical or non-clinical. The GNS works with the GCA to address all clinical issues identified in this grievance process. If a grievance is identified as containing both an appeal of a benefit denial and another grievance issue, each of these will be addressed separately, as noted below.
   c. Quality of Care Grievances: The GNS reviews all grievances for potential quality of care issues.If a potential quality of care issue is suspected, the GNS forwards the grievance with supportingdocumentation to the Chief Medical Officer (CMO) or physician designee for secondary review. If the CMO or physician designee confirms a potential quality issue (PQI), the case is referred to the Patient Safety team within the Partnership Quality Improvement (QI) department for further investigation as described in MPQP1016 Potential Quality Issue Investigation and Resolution. If the physician does not believe a PQI referral is warranted, but the GNS disagrees, the GNS may nonetheless make a PQI referral to the QI department. Quality of care grievances that are found to be without merit by the GNS and the Medical Director are tracked, but not referred to the QI department for further investigation and action.
   d. Other clinical issues identified by the GNS may include access issues, quality of

service issues(including alleged discrimination), and quality of facility issues. As the GNS and GCA review incoming grievances, they may determine that the grievance is unfounded, or non-specific and not actionable, and thus not appropriate for referral to another department for investigation. If the non-quality of care grievance requires further investigation, it may be referred to a department within Partnership. Common referrals to other Partnership departments include:

1) Provider Relations department to address some access issues (for example phone access and waiting room access) and quality of service issues (for example, staff rudeness or clinician miscommunication) with the individual provider or institution. In general, if sufficient and specific information is received in the grievance, such grievances are shared with the management of a site and a response is requested, including self-identified corrective actions if applicable. If the response is judged to be insufficient by the Grievance or Provider Relations staff, the case may be referred to the CMO or physician designee for immediate review.
2) Care Coordination department to address access issues, such as finding a specialist or getting in to see their assigned PCP. According to Care Coordination policy and the judgment of the Care Coordination nurses and managers, such cases may be escalated to department directors or a Partnership Medical Director if the resolution of the grievance is not possible through normal interventions by Care Coordination staff and the member's health is at risk from this lack of resolution of the care coordination issue.
3) QI's Member Safety-Quality Inspections Team to evaluate facility quality and safety through the Facility Site Review process. The severity and scope of issues are assessed to decide on appropriate follow-up actions.
4) Health Equity department for accusations of discrimination, lack of translation, or cultural incompatibility. This procedure is describedin policy CGA022.
5) Member Services department management for problems with the initial member servicesresponse to grievances.
6) Compliance department for alleged Health Insurance and Portability and Accountability Act (HIPAA) violations or alleged fraud, waste or abuse.
7) Partnership leadership for Partnership process issues identified.

e. Exempt and standard grievances are recorded and documented in the case managementsystem (Everest).
f. Partnership receives grievances when a member is dissatisfied about non-covered services. For grievances involving a decision where the requested service is not a covered benefit, the member is offered the right to file an appeal. The resolution will specify the policy or Evidence of Coverage (EOC) that excludes the service. The resolution letter will identify the document and page number where the provision is found. The resolution letter will direct the member to the applicable section of the EOC containing the provision or provide a copy, if requested, of the

applicable policy. The resolution letter will explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested by the member.

H. Expedited Grievance Process

If a member or a treating physician requests an expedited review or if the MSR or other Partnership staff determines expedited review is needed, the issue will be immediately forwarded to Partnership's Medical Directors to render a determination as to whether an expedited review is appropriate. For expedited grievances regarding denial of a request for expedited resolution of an appeal, the Medical Director reviewing the expedited request must have the clinical expertise in treating the member's condition or disease. Resolutions onexpedited reviews include an oral and written notification. The process is as follows:

1. Presentation of Evidence, Facts and Law in Support of Member's Grievance
   Members are advised of their rights to submit evidence, facts and law in support of their grievance.Members are also informed by the GCA of the limited time available to present evidence due to the nature of the expedited review request.
2. Expedited Review/Grievance Request Approved
   If Partnership's Medical Director determines that the grievance involves an imminent and serious threat tothe health of the member, including, but not limited to: severe pain, potential loss of life, limb or major bodily function, the grievance will be handled as an expedited grievance. Grievance staff willnotify members verbally that their request for an expedited review has been approved and their casewill be processed within 72 hours.
3. Expedited Request Denied
   If Partnership's Medical Director determines the expedited review process is not necessary, the regular grievance process is followed. Members will be notified verbally by Grievance staff that their requestfor an expedited review has been denied within 72 hours of their request and the grievance will be processed using standard timeframe (30 calendar days).

I. Incoming Grievances

1. When a grievance is received into the Grievance unit, the Grievance Associate (GA) or designee will assign the grievance to a GCA using the Grievance Rotation Tracker.
2. Upon assigning the case, an email is generated to all Grievance staff, including the GNS. The GNS will log into the grievance system to evaluate if the case is a clinical or non-clinical grievance. An assessment note will be placed in the grievance system under the "Case Confirmed-Clinical" or "Case Confirmed-Non-Clinical" action by the GNS. Grievance staff will assess the grievance for other referrals to Partnership departments.
3. All clinical cases are reviewed by the GNS or designee to evaluate the need to forward the case to the QI department for a PQI and/or order records for further evaluation. The GNS or designee will direct Grievance staff if a PQI referral is needed. The GNS or designee will also make recommendations for casework on any clinical cases.

J. Clinical Grievance
A clinical grievance is defined as any issue concerning the member experience provided by a clinic, hospital, or provider. The types of grievances considered to be clinical in nature include:
1. Quality of Service (by clinic/hospital/provider)
2. Access
3. Quality of Medical Care
4. Denials, Refusals (denial of service/treatment) by provider, and not by Partnership
5. Cultural, Linguistic, and Health Education (by clinic/hospital/provider)
6. Transportation Related Grievances

K. Non-Clinical Grievance
A non-clinical grievance is defined as any issue concerning the services provided by Partnership and its non-clinical components. The types of grievances considered to be non-clinical in nature include:
1. Billing
2. Benefits/Coverage
3. Cultural, Linguistic, and Health Education (by Partnership staff, Partnership materials)
4. Quality of Service (by Partnership staff)
5. Enrollment (cancellation of coverage, premium increase, denial of enrollment)
6. Transportation Related Grievances

L. Quality of Medical Care Grievances
1. All quality of medical care grievances are reviewed by Partnership clinical staff to assess the member's concern for accuracy. For example, it is not unusual for a patient to feel their treatment was incorrect, when in fact it was correct (medical records show that the treatment plan prescribed by theprovider is clinically sound).
2. The designated Partnership clinical staff will base their determination on the review of information submitted by the member or their authorized representative. The review will also consist of review of medical records and claims history.
3. All quality of care grievances are reviewed by a GNS and submitted to the CMO or physician designee for review within a timeframe, which is appropriate for the nature of the member's condition. If there is a potential safety issue determined by the GNS or QI Nurse, documentation of the issue will be reviewed by the QI department.

M. Inter-Rater Reliability (IRR)
1. To ensure that grievances are appropriately designated by the GNS as clinical versus non-clinicaland referrals for PQIs are accurately being referred to the QI department, IRR studies will be conducted every quarter.
2. Sample will be prepared by the Grievance Manager or designee.
   a. PQI Referral Sample - A random selection of a minimum of 10 grievances will be pulled for review by the CMO or designee to determine whether the decision to not refer the case to QI as a PQI was appropriate.
   b. Clinical vs Non-Clinical Sample- A selection of a minimum of 10 grievances will be pulled for review by the CMO or designee to determine whether the

categorization of a grievance, clinicalor non-clinical was appropriate.

3. Timeframe – IRRs will be completed on a quarterly basis and reported to the Member GrievanceReview Committee.
4. Results - A 90% IRR is required. Where a 90% score is not achieved, additional training will be provided to the GNS by the QI designated staff member and subsequent IRR studies will be conducted until the passing score is achieved.

N. Grievances Involving Coverage For Terminally Ill Members

A member who has a terminal illness (incurable or irreversible condition that has a high probability of causing death within one (1) year or less) requires the following procedure for addressing a coverage denial.

1. Within five (5) business days of a denial of a benefit for treatment, services, or supplies deemed experimental as recommended by a participating plan provider, Partnership will provide to the member thefollowing information.
   a. A statement setting forth the specific medical and scientific reasons for denying coverage.
   b. A description of alternative treatment services or supplies covered by the plan, if any. Compliance with this subdivision Section 1368.1 of the Act, by a plan shall not be construed tomean that the plan is engaging in the unlawful practice of medicine.
   c. Copies of the plan's grievance procedures or grievance form. The grievance form shall providean opportunity for the member to request a conference as part of the plan's grievance system provided under Section 1368.1.
2. If the member requests a conference, the conference will be held within five (5) business days if thetreating participating physician determines, after consultation with the health plan Medical Director,based on standard medical practice, that the effectiveness of either the proposed treatment, services,or supplies, or any alternative treatment, services, or supplies covered by the plan, would be materially reduced, if not provided at the earliest possible date. The member will also be given the option to extend the timeframe to request to participate in the conference up to 30 calendar days.

O. Contacting Providers Regarding Grievances Filed Against Them

1. Members are notified at the time of the filing that their grievance may be sent to the provider they

   are grieving about to receive a response regarding their grievance. Members may request that any notification to their provider or practitioner regarding the grievance be delayed until a relationship with a new provider or practitioner is effective. Such a request is noted when the grievance is filed by the Partnership staff member. Partnership staff will assure the member that there will be no discrimination against them by Partnership or its providers or practitioners on the grounds that they have filed a grievance.

P. Member Grievance Correspondence

1. There are two (2) types of member correspondence issued by grievance staff, the acknowledgment letter and resolution letter. When translation is required, a fully translated version of these letters will be mailed. Of note, each member

correspondence includes Partnership's Nondiscrimination notice and the Your Rights under Medi-Cal Managed Care notice. For discrimination grievances,the member will be provided information on disputing or appealing the decision with the U.S. Department of Health and Human Services, Office of Civil Rights.

a. Acknowledgment Letter
    1) An acknowledgment letter is issued within five (5) calendar days of receipt of a grievance. This letter will include the date of receipt, name, address and phone number of the Partnership GCA who has been assigned to their case and the phone number for the California Relay Service.
    2) Exception to sending the acknowledgment letter
        a) If a grievance is resolved within five (5) calendar days of receipt, the GCA will issue only the resolution letter.
b. Resolution Letter
    1) The GCA mails a resolution letter within 30 calendar days of the date the grievance was received. The letter summarizes the grievance and describes the resolution. If the outcome of the grievance includes an adverse benefit decision, the member will be advised of how to appeal the decision in the resolution letter, and the "Your Rights" attachment will be included.

Q. Time Frame - Grievance
1. Standard:
    a. Member grievances are resolved within 30 calendar days of the member's requestfor a grievance [Title 22 CCR 53858 (f) (1)]. In the event that resolution of a standard grievance is not reached within 30 calendar days, Partnership will notify the member in writing of the status of the grievance and the estimated date of resolution.
2. Expedited:
    a. Grievance staff will process the case within 72 hours from the date of receipt of the grievance.

R. Grievance File Maintenance

Documentation for each grievance is maintained by the GCA. Documentation may include, but is not limited to the following:

1. Memo outlining the grievance and the steps taken to resolve the issue;
    a. The date of the call
    b. The name of the complainant
    c. The complainant's member identification number
    d. The nature of the grievance
    e. The nature of the resolution
    f. The name of the plan representative who took the call and resolved the grievance
    g. Request for an Appeal or Grievance Form
    h. Acknowledgment Letter
    i. Additional written correspondence between Partnership, the member, providers

and/or practitioners

j. Billing and claims information (if appropriate)

k. Medical Records Release Form (if appropriate)

l. Medical records (if appropriate)

m. Grievance resolution letter

n. Notice of unresolved grievance (if appropriate)

Copies of grievances and responses shall be maintained by Partnership for ten (10) years. MEMBER APPEAL PROCESS

S. Time Frame – Appeal

Appeals must be filed within 60 calendar days following any denial action that is the subject of the member's dissatisfaction. Appeals can be filed by the member, their authorized representative, or a provider on behalf of a member either orally or in writing. If a member files an oral appeal, the MSR or Grievance staff will request the member to provide a written, signed appeal. The oral appeal establishes the filing date of the appeal. Partnership will proceed with handling of the appeal if the written signed appeal is not received. There is only one level of appeal for members at the MCP level, per 42 CFR 438.402(b).

T. Resolving Member Appeals

1. Confirmation of member appeal
   a. Upon receipt of an appeal, Grievance staff conducts a preliminary investigation of the request byidentifying the substance and reason for the appeal and reviewing any additional clinical and/or other information submitted with the appeal. The Grievance staff will review any previous denials, the appeal history, and the timeline of activities leading up to the current appeal, before contacting the treating provider, Partnership staff and any other appropriate individuals to gather information. Grievance staff will also contact the member to confirm the appeal and provide the member an opportunity to submit a statement for the reason for the appeal. When investigating the appeal, Partnership staff will not give deference to the denial decision.
2. Presentation of evidence, facts and law in support of member's grievance
   a. Members are advised of their rights to submit evidence, facts and law in support of their grievance and are given 10 calendar days to submit the documentation. Upon request, the member has the right to request reasonable access to their appeal case file, including medicalrecords and any other documents before and during the appeal process.
3. Continuation of benefits (also known as aid paid pending)
   a. Grievance staff will assess if the member's benefit/service can continue pending the outcome of the appeal decision.
      1) The criterion for continuation of benefits are listed below per 42 CFR 438.420
         a) Requests must occur within 10 calendar days from the date the NOA was mailed to the member.

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b) The appeal must be filed timely.
c) The appeal involves the termination, suspension, or reduction of a previouslyauthorized course of treatment.
d) The service was ordered by an authorized provider.
e) The original period covered by the original authorization has not expired.

b. Duration of continued or reinstated benefits
   1) If Partnership continues or reinstates the member's benefits while the appeal is pending, the benefits will be continued until one of the following occurs:
      a) The member withdraws the appeal.
      b) 10 days after Partnership mails the NAR, or, if the member requests a state hearing within the 10-day timeframe, the benefits will be continued until a state hearing decision is reached.
      c) The state hearing office issues a hearing decision adverse to the member.
      d) The time period or service limits of a previously authorized service has been met.

c. Partnership must pay for disputed services if the member received the disputed services while the appeal or state hearing was pending. Consistent with 22 CCR § 51002 regarding prohibitions in collecting reimbursement from Medi-Cal beneficiaries, Partnership must ensure the member is not billed for disputed services even if the final resolution of the appeal or state hearing is adverse to the member, that is, upholds Partnership's adverse benefit determination.

U. Examples of Member Appeals
   1. An appeal is a member's request for reconsideration of an initial decision resulting in the denial ofservice, benefit or claim. Appeals may address, but are not limited to, the following issues:
      a. Appeals of denied TARs
      b. Appeals of level-of-care determinations
      c. Appeals of Partnership claims payment denials
      d. Appeals of primary care physician request for disenrollment
   2. Members filing grievance regarding their Medi-Cal eligibility are referred to their local county Health and Social Services Department or the Social Security Administration office for assistance.

V. Review of Appeals
   1. Medically Related Appeals
      a. Grievance staff will refer medically related appeals and all documentation to the Medical Director for review who was not part of the original decision to deny, nor a subordinate of theoriginal decision maker, unless the final decision is in favor of the member (Contract Exhibit A,Attachment 14, 2, F). The "health care professional with appropriate expertise" is not determined by specialty, but by expertise and experience which varies with the career and experience of the particular Medical Director. In general, if the appeal is about a child, then a pediatrician or family physician Medical Director would be consulted. If the appeal is about an adult, then one of the internal medicine physicians or family physicians would be consulted. If the Medical Director reviewing the appeals feels that the particular clinical issue in question is outside their expertise or experience, they may refer the case to another Medical Director for review (who was not part of the original decision to deny, nor a subordinate of the original decision maker) or to an outside physician consultant with expertise in this area.
         1) Ordering Medical Records
            The Medical Director will direct grievance staff to order medical records from primary careproviders and/or other treating physicians if needed. Medical providers are expected to respond to requests for medical records within five (5) working days.
   2. Other Appeals
      a. Appeals regarding claims, billing issues, special cases status and other non-medically-related cases may be presented to the Member Grievance Review Committee for departmental review of the resolution as needed. The staff reviewing the appeal will be individuals who were not involved in the initial determination nor a subordinate of the original decision maker unless thefinal decision is in favor of the member.
   3. Expedited Appeals
      a. Requests for expedited appeals will be immediately forwarded to a Medical Director for review. If the expedited review is deemed medically necessary, the

appeal resolution will be provided within 72 hours. The GCA will make reasonable efforts to notify the member orally and provide written notice within 72 hours.

W. Member Correspondence

1. There are two (2) types of member correspondence that are issued by Grievance staff. When translation is required, a fully translated version of these letters will be mailed.
   a. Acknowledgment Letter
      1) An acknowledgment letter is issued within five (5) calendar days of receipt of an appeal.
      2) This letter will include the receipt date, name, address and phone number of the GCA who has been assigned to their case and the phone number for the California Relay Service.
      3) Exception to sending the acknowledgment letter
         a) If an appeal decision is rendered within five (5) calendar days of receipt, the GCA will issue only the appeal decision letter.
      4) Denial of Expedited Review
         a) If a request for an expedited review has been denied by a Medical Director, grievancestaff will also include in the acknowledgment notice that the request for an expedited review has been denied and the reason why the request was denied.
   b. Notice of Appeal Resolution Letter
      1) For preservice and post-service appeals, the GCA mails an appeal resolution letter within 30 calendar days from the date the appeal was received. The letter summarizes the appeal and describes the appeal decision. Appeal decisions to uphold the denial include the rationale specific to the member's condition or reason for the request so the member or their representative understand what is needed to file the next level of appeal. The letter is written in easy-to-understand language that includes the complete explanation of the grounds for the denial, without the use of abbreviations or acronyms that are not defined or health care procedure codes that are not explained. The appeal resolution letter will reference the benefit provision, guideline, protocol or criteria, which the appeal decision is based upon. Also, the letter will notify members that they have access to all copies and documents that
      are relevant to the appeal, free of charge. The appeal resolution letter will also list the titles and qualifications, including specialties of individuals participating in the appeal review. All appeal resolution letters will include state hearing rights when appropriate. If any appeal resolution timeframe is not met by Partnership (i.e., standard or expedited), the member isconsidered to have exhausted Partnership’s appeals process and may proceed to a state hearing.

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2) Partnership will authorize or provide services for overturned adverse benefit determinations (as theresult of an appeal determination) as expeditiously as the member's health condition requires, but no later than 72 hours after the decision.

c. Notification
Each notification template (i.e., Notice of Appeal Resolution, "Your Rights" attachments) when informing members of a denial or appeal resolution will either be DHCS templates or be submitted to DHCS for review and approval prior to use. Member correspondence includes Partnership's Language Taglines, Nondiscrimination notice, and "Your Rights Under Medi-Cal Managed Care". These notices provide the member information regarding Partnership's grievance process including the member's rights to file a state hearing.

VII. MEMBER STATE HEARING PROCESS

A. Member State Hearing Timeframe
State Hearings must be filed within 120 calendar days following the date of the NAR that is subject of the member's dissatisfaction. State hearings can be filed by the member or their authorized representative. For the purpose of this policy, the term "member" will be used to refer to the member and their authorized representative unless otherwise noted.

B. Filing a State Hearing
1. Members have the right to file a state hearing after exhausting Partnership's appeal process or in instances of deemed exhaustion as defined in III.F above.
2. Members can file a state hearing with the California Department of Social Services. There arefour ways to request a state hearing.
   a. By Phone
   Members can call the State Hearing Office at 1-800-743-8525. Hearing impaired members mayuse TTY by calling 1-800-952-8349.
   b. By Mail
   Members can send a hearing request form or their own written request directly to:California Department of Social Services
   State Hearings Division
   P.O. Box 944243, Mail Station
   9-17-433Sacramento, CA
   94244-2430
   c. By Fax
   Members can fax their hearing request form or their own written request directly to the state at 916-309-3487 or 833-281-0903.
   d. In Person
   Members can also turn in their hearing request form or their own written request at one of the local county offices.

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3. Partnership will assist members with preparing for the State Hearing by providing the member with their case file, including medical records, other documents and records, guidelines, clinical criteria, and any new or additional evidence relied on for the initial or appeal denial.

C. Responding to State Hearing Requests

1. Notification of Hearing Request
   Partnership receives a notice of the member's request for a state hearing from the SCOPE unit in theCalifornia State Department of Social Services and from the Office of the Ombudsman.
   Notifications include the case name, the request for hearing and filing date.
2. Review of Hearing Request
   Upon receipt, grievance staff conducts a preliminary investigation of the request by contacting the treating provider, Partnership staff and any other appropriate individuals to gather information. Grievancestaff will also contact the member to confirm the state hearing and to also provide the member an opportunity to submit a statement for the reason for the hearing. If the member has not opened an appeal with Partnership, staff will offer to open an appeal as well.
3. Parties to State Hearings
   The parties to the state hearings include Partnership, the member and their representative or therepresentative of a deceased member's estate.
4. Continuation of Benefit
   a. Upon request, the member's benefit/service can continue pending the outcome of the statehearing decision.
   b. The criteria for continuation of benefits are listed below per 42 CFR 438.420.
      1) Request must occur within 10 calendar days from the date the notice of action was mailedto the member.
      2) The state hearing must be filed timely.
      3) The state hearing involves the termination, suspension, or reduction of a previouslyauthorized course of treatment.
      4) The service was ordered by an authorized provider.
      5) The original period covered by the original authorization has not expired.
   c. Duration of continued or reinstated benefits
      If Partnership continues or reinstates the member's benefit while the state hearing is pending, the benefits will be continued until one of the following occurs:
      1) The member withdraws the state hearing
      2) The state hearing office issues a hearing decision adverse to the member
      3) The time period or service limits of a previously authorized service have been met

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d. Disputes regarding continuation or reinstated benefits
In the event grievance staff finds that the member does not meet criteria for continuation or reinstated benefits, the member will be referred back to the Office of the Ombudsman to reviewand render a decision if aid paid pending applies.

D. Creation of Statement of Position
Grievance staff, while working with clinical Partnership staff, will prepare the Statement of Position. The Statement of Position will state the following information:
1. The Issue
2. The Background
3. Pertinent Facts
4. Guidelines
5. History of TAR
6. Applicable Law
7. Conclusion

E. Submission of Statement of Position
Statements of Positions are submitted directly to the state hearing SCOPE office, the Office of the Ombudsman, and to the member, at least two (2) working days prior to the scheduled hearing. To ensure receipt prior to the hearing. Partnership will upload it to the Appeals Case Management System (ACMS) The ACMS is the online website used to manage State Hearings. Grievance staff will send the Statement of Position via FedEx to the member. FedEx envelopes will require direct signature for delivery. In the event a physical address cannot be obtained or is not available, Statement of Positions will be mailed via certified mail to the member's PO Box.

F. Representation during the State Hearing
1. Grievance staff will appear at the state hearings to represent Partnership and explain Partnership's position. Appropriate Partnership staff and/or other representatives may be asked to appear at the state hearings asdetermined necessary by the Medical Director.

G. Expedited State Hearings
1. Within two (2) working days of being notified by the Department of Social Services (DSS) or the Office of the Ombudsman that a member has filed a request for a state hearing which meets the criteria for expedited resolution, Partnership will deliver directly to the designated/appropriate DSS Administrative Law Judge, all information and documents which either support, or which Partnership considered in connection with, the action which is the subject of the expedited state hearing. This includes, but is not limited to, copies of the relevant TAR, NOA, and NAR. If the NOA or NAR are not in English, fully translated copies shall be transmitted to DSS along with copies of the original NOA and NAR. One or more plan representatives with knowledge of the member's condition and the reason(s) for the action, which is the subject of the expedited state hearing, shall be available by phone during the scheduled state hearing.

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H. State Hearing Decisions
   1. Per 42 CFR 431.244(f)(1), the State must issue a final decision on the state hearing within 90 calendar days of the date of request for hearing, this timeframe is detailed in the "Medi-Cal Your Rights" document enclosed with NOA/NARs. The notice of the Administrative Law Judge's decision will provide members with information on how to request a rehearing of their issue if they disagree with the decision. A member may obtain judicial review of the decision by filing a petition in Superior Court under Code of Civil Procedure§1094.5 within one year after the date of the decision.
      a. Upheld Decisions
         Decisions favorable to Partnership will be noted in the grievance system case file and closed. A copyof the decision is forwarded to the department that rendered the adverse decision to the member.
      b. Overturned Decisions
         Adverse decisions to Partnership will be noted in the grievance system case file. A copy of the decision is forwarded to the department that rendered the adverse decision to the member andwill be given 72 hours to overturn the decision; expedited hearings will require the denial be overturned within 24 hours. Once confirmation is received that the decision is overturned, grievance staff will contact the member and the Office of the Ombudsman and verbally notifythat the denial has been overturned. Interactions with the member and the Office of the Ombudsman are documented in the grievance system case file and the case is closed once a copy of the overturned decision is available. Partnership will pay for disputed services if the member received the disputed services while the State Hearing was pending.

I. State Hearing File Maintenance
   1. All documentation relating to a state hearing is scanned and uploaded into the grievance systemunder the member's case number. Documentation includes but is not limited to the following:
      a. Case Summary (produced out of grievance system) outlining the state hearing and the stepstaken to resolve the issue
      b. Notification of State Hearing
      c. All written correspondence between Partnership, the member, providers and/or practitioners
      d. Billing and claims information (if applicable)
      e. Statement of Position
      f. Administrative Law Judge's decision on the hearing

J. Monitoring of Timeliness of Grievances
   1. All grievances, appeals and state hearing requests with their resolutions are documented in thegrievance system.
   2. At the end of each month, the grievance system manager or their designee will review the grievance staff cases as part of their performance review. In addition, all grievances and appeals pending and unresolved for 30 days or more are reviewed.

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3. Monthly meetings, or more often if needed, are conducted with staff to ensure that member grievances and appeals are resolved within established timeframes as well as to review open member grievancesand appeals and determine appropriate resolutions.

K. Reporting Grievances to HealthPlan Committees for Review

1. Under the direction and oversight of the CMO, individual and aggregate data on member grievances and appeals is reviewed by the Member Grievance Review Committee(MGRC), Internal Quality Improvement (IQI), and Quality/Utilization Advisory Committee (Q/UAC) no less than 4 times per year. Each committee reviews the data for possible actions as determined appropriate according to Partnership Quality Assurance Protocol. On a quarterly basis, all grievances related to access to care, quality of care and denial of services will be reviewed and analyzed by committee to remedy any problems identified. On an annual basis, Partnership's Consumer Advisory Committee (CAC) will review the written record of Grievance and Appeals.

VIII. EXEMPT GRIEVANCE PROCESS

A. Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the end of the following business day, are categorized as exempt grievances and are exempt from the requirement to send a written acknowledgment and response. If the exempt grievance is resolved by theend of the following business day, the grievance will remain categorized as "exempt". If the exempt grievance is not resolved by the end of the following business day, it will be processed as a standard grievance, with the rights of the standard grievance timelines. All grievances are clearly listed on a universal grievance log.

B. All exempt grievances are reviewed by the GNS within three (3) days to determine whether the grievance has potential quality of medical care issues. The GNS will base their determination on the review of information submitted by the member or authorized representative. The review may also consist of a review of medical records already obtained by Partnership for utilization management purposes, care coordination notes and claims history. If the GNS determines a clinical issue identified, they will submit the exempt grievance to the CMO or physician designee for review within a timeframe, which is appropriate for the nature of the member's condition. Either the GNS or the CMO/physician designee may determine, based on their clinical judgement, that the exempt grievance warrants individual attention by a Partnership department, and refer the case for intervention (similar to interventions done for non-exempt grievances, summarized in section G.2.d, Resolving Member Grievances, above).

IX. REPORTING REQUIREMENTS

A. Partnership maintains an inquiry log of all requests for information that do not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits,or other Partnership processes.

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<tr><td rowspan="2">Approving Entities:</td><td>☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO ☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 02/12/2025</td></tr>
</table>

B. Partnership maintains and has available for DHCS' review, Partnership's grievance logs, including copies of the grievance logs of any subcontracting entity delegated with the responsibility to maintain and resolve grievances and the Partnership exempt grievance log. Grievance logs are maintained based on the requirementsset forth in Title 22 CCR Section 53858 (e).
   1. Date and time the grievance was filed
   2. The name of the member filing the grievance
   3. Member identification number
   4. The name of the person receiving the grievance
   5. A description of the grievance
   6. A description of the action taken to resolve the grievance
   7. The proposed resolution by the plan
   8. The name of the person responsible for resolution
   9. The date of notification to the member

C. The information contained in this log shall be reviewed by Partnership's Board and Partnership's CMO or physician designee on an annual basis.

X. MEDICAL RECORDS/DOCUMENT REQUESTS:

A. Members and providers may call to request materials and/or letters related to their Grievance/Appeal/State Hearing to be sent to them by mail or by fax.

B. Members can request their case file free of charge by calling Partnership's Member Servicesdepartment.

XI. REFERENCES:

A. Partnership Contract 08-85215 A19
B. 22 CCR §53858
C. 22 CCR § 51002
D. 28 CCR §1300.68 [except subdivision §1300.68(c),(g) and (h)]
E. 28 CCR §1300.68.01[except subdivision §1300.68.01(b)and (c)]
F. 42 CFR 438.420(a)(b) and (c)
G. 42 CFR 438.406(b)(3)
H. California Department of Health Care Services (DHCS) All Plan Letter (APL 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services (revised May 3, 2022, supersedes APL 17-011)
I. DHCS APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates (Aug. 31, 2021, supersedes APL17-006)
J. DHCS APL 22-002 Alternative Format Selection for Members with Visual Impairments (March 12, 2022)
K. NCQA 2025 Standards and Guidelines: Member Experience 7A-7B
L. NCQA 2025 Standards and Guidelines: Utilization Management 8A-9A-9B-9C-9D

XII. DISTRIBUTION:

Policy/Procedure Number: CGA024				**Lead Department: Administration** Business Unit: Grievance & Appeals	
Policy/Procedure Title: Medi-Cal Member Grievance System				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 02/11/99 (MS 300)			**Next Review Date: 02/12/2026** **Last Review Date: 02/12/2025**		
Applies to:	☐ **Employees**		☒ **Medi-Cal**	☐ **Partnership Advantage** [1]	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date: 02/12/2025**	

A. Partnership Department Directors
B. Partnership Provider Manual

XIII. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Grievance & Appeals Compliance Manager

XIV. REVISION DATES:

Medi-Cal

MS- 06/4/99; 04/25/00; 05/17/00; 06/19/00; 07/09/02; 10/25/02; 02/19/03; 02/23/04; 05/11/04; 01/17/06;01/16/08; 03/18/09; 07/21/10; 03/20/13; 11/18/15; 06/21/17; 03/13/19; 3/11/20; 5/12/21; 08/10/22; 10/11/23; 02/14/24; 2/12/25

PREVIOUSLY APPLIED TO: N/A