PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: CGA024 (previously CGA-003; Health Services [HS] MCQP1034; Member Services [MS] policy #300)</td><td colspan="3">Lead Department: Administration</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Medi-Cal Member Grievance System</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 02/11/99 (MS 300)</td><td colspan="4">Next Review Date: 05/11/2022
Last Review Date: 05/12/2021</td></tr>
<tr><td>Applies to:</td><td>☒ Medi-Cal</td><td></td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td>☒ IQI</td><td>☐ P & T</td><td colspan="3">☒ QUAC</td></tr>
<tr><td>☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td colspan="2">☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ 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: 05/12/2021</td></tr>
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I. RELATED POLICIES:

A. MCNP9003 Cultural and Linguistic Services
B. MPQP1016 Potential Quality Issue Investigation and Resolution
C. MCUP3037 Appeals of Utilization Management/Pharmacy Decisions
D. MPQP1022 Site Review Requirements and Guidelines

II. IMPACTED DEPTS:

A. Member Services
B. Grievance
C. Provider Relations
D. Health Services
E. Claims

III. DEFINITIONS:

A. Acknowledgment Letter is a written notification of receipt of a grievance or appeal that is sent to the member or the members authorized representative.
B. Appeal is a member's request to Partnership HealthPlan of California (PHC) 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.
C. 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 which includes the following:
    1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, 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 to act within the required timeframes for standard resolution of Grievances and Appeals.
    6. For a resident of a rural area, the denial of the member's request to obtain services outside the network.
    7. The denial of a member's request to dispute financial liability.
D. Authorized Representative is a relative, friend, attorney or other person authorized by the member to

represent him/her in matters regarding his/her healthcare.

E. Complaint is the same as a Grievance. See Grievance definition.
F. Expedited Review is the process by which a decision is rendered when a grievance involves an imminent and serious threat to the health of the member, including, but not limited to: severe pain, potential loss of life, limb or major bodily function. Expedited reviews are approved by physician reviewers. An expedited review is also acknowledged verbally, whenever possible.
G. 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 received over 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.
    3. Second Level Grievance is an appeal of a grievance that has been denied.
H. Grievance Clinical Nurse (GCN) is the clinical staff member responsible for initiating and coordinating a multidisciplinary team approach to handling of grievances with members, providers, plan Medical Director, 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 clinical lead may also provide input or participate in state hearings.
I. Grievance Coordinator is the staff member who is responsible for summarizing, analyzing, investigating and issuing acknowledgments and resolutions to member grievances and appeals. The Grievance Coordinator also represents PHC during state hearings.
J. Grievance system is the computer system that PHC uses to log and track member grievances, appeals, and state hearing requests which are logged by specific grievance types.
K. Inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to; questions pertaining to eligibility, benefits, or other PHC processes. Where PHC is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.
L. Member is the Medi-Cal eligible individual receiving health care through PHC to whom reference will be made as "member" in all protocols.
M. 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 representatives from Grievances, Member Services, Provider Relations, Care Coordination, Quality, Pharmacy, Utilization, and Compliance.
N. Member Services Representatives (MSR's) are the PHC staff members who assist members or their authorized representatives in learning about and understanding the services and benefits offered through PHC, including the grievance, appeal and hearing procedures, and assist members in obtaining resolution to their issues.
O. Non-Contracting Provider or Practitioner is a health care provider who does not have a contract with PHC, but may do business with PHC for specific reasons, e.g., provision of emergency, out-of-area or one-time member care.
P. Notice of Action is a formal letter informing a member of an Adverse Benefit Determination.
Q. Practitioner is a licensed individual who provides medical care.
R. Primary Care Provider (PCP) is a physician who has executed an agreement with PHC to provide the services of a primary care physician.
S. Provider is an organization such as a hospital, residential treatment center or rehabilitation facility.
T. Remark System (RS) is the AMISYS computer system that PHC uses to log and track specific grievance

types that are resolved by the end of the following business day. This system is also used by staff to make notes and document other issues relating to a grievance, appeal or state hearings.

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

V. State Hearing is a grievance or appeal filed by the member or member's representative to the California Department of Social Services to be heard by 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 hearing requests as well as to ensure PHC's responsiveness to issues raised by PHC members. The sections below outlines the various components to the Grievance System as well as the process for each type of grievance. This policy is written in accordance with PHC's contract with the Department of Health Care Services (DHCS) Exhibit A, Attachment 13, 14, All Plan Letter 17-006, 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 CFR 438.420(a)(b) and (c) and 42 CFR 438.406(b)(3).

VI. POLICY/PROCEDURE:

A. Member Rights

PHC takes member grievances, appeals and state hearings seriously and strives to reach a fair resolution after a thorough evaluation of each issue. PHC will address all grievances, appeals and state hearings in a timely and efficient manner and ensure that members are given reasonable opportunity to present in writing or in person before the individual(s) resolving the grievance, evidence, facts and law, in support of their grievance. 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 PHC against a member on the grounds that the member filed 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 and Health Services staff.
6. Any member whose grievance is resolved or unresolved has the right to request a state hearing. Submissions of a grievance are not constructed as a waiver of the member's right to request a state hearing.
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 necessary corrective 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 their grievance and are given 14 calendar days to submit the documentation.

B. Cultural and Linguistic Requirements

1. A member has the right to language translation during any part of the grievance process, within a reasonable timeframe, including standard documents and correspondence. PHC's policy MCLP7002 Cultural & Linguistic Services details PHC's system for addressing cultural and linguistic requirements. The procedure for review of member grievances ensures that all grievances are reviewed by grievance coordinators for any cultural and linguistic issues. Training is provided on a yearly basis.

C. How grievance processes are communicated to PHC members

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

1. Written Materials – The PHC member grievance process explaining how to file a grievance is printed in the PHC Evidence of Coverage/Disclosure Form. It is included in the PHC Member Newsletter at least once each year, mailed with all grievance and appeal acknowledgment and resolution letters and on notifications of all treatment authorization request (TAR) denials.
2. Oral Communication – Telephone calls with PHC staff and PHC Providers and/or Practitioners.
3. Contracting Provider – Member Grievance forms and a description of the grievance process is available at each contracting provider's office.
4. PHC Website – PHC maintains a Website on the Internet which provides member grievance forms and information to members on how to file a grievance with PHC and the expedited medical review process.
5. Items 1, 3 & 4 above all include the toll-free phone number, Internet address, and the toll-free phone number for the hearing and speech impaired for PHC. PHC address is also included.

D. Member Grievance Process

Grievances may be filed at any time following any incident or action that is the subject of the member's dissatisfaction. 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 methods members or a member's authorized representative may use to file a grievance:

1. By Telephone
   The member can contact PHC's Member Services Department to file a verbal grievance. PHC uses both bilingual staff and interpreter services for members who speak other languages (in accordance with Title 22 CCR 53858). A Member Services Representative (MSR) will record the grievance into PHC's grievance system.
2. In Writing
   The member may also submit his/her grievance in writing to PHC. Upon request, members can request a member grievance form from PHC or from a contracted provider office. The member grievance form contains information regarding the PHC member grievance system as well as an authorized representative form.
3. In Person
   Members may also visit PHC's offices in Fairfield and Redding and 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 Authorized Representative Form to authorize someone of their choice to represent them.

4. Contracted Provider
   Members may file a grievance at one of PHC's contracting providers' offices. The form titled "Member Grievance Form" is available at all contracted provider offices (in accordance with Title 22 CCR 53858).
5. PHC website
   Members can file a grievance by visiting PHC's website at: http://www.partnershiphp.org/Members/Medi-Cal/Pages/Complaint,-Appeal-and-Hearing.aspxh and select "Online Grievance Form" to file their grievance electronically through PHC's secure server.

F. Delegation
1. PHC delegates the grievance process, or portions thereof, to Kaiser Health Plan and Beacon Health Strategies (Beacon) with the exception of Substance Use Disorder (SUD) related grievances pertaining to the Drug Medi-Cal Organized Delivery System (DMC-ODS).
2. PHC oversees the delegation of the grievance process conducted by these entities through quarterly reviews of the grievance logs and annual audits.
3. PHC requires corrective action plans whenever PHC designated staff identifies a problem in any of these entities process and assigns a deadline for receiving evidence that the problem has been resolved.

G. Resolving Member Grievances
The steps to resolve a member's grievance will occur as outlined below, which is established by the date PHC receives the grievance.
1. The following documents are sent to the member by the grievance staff within five (5) calendar days of 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 Grievance Coordinator who may be contacted about the grievance or the appeal and the toll-free phone number for hearing and speech impaired members.
2. "Frequently Asked Questions about the Grievance Process," which describes PHC's procedures for filing and resolving grievances and the telephone number and address for presenting a grievance. As appropriate, the Grievance Coordinator will conduct a preliminary investigation by contacting medical staff, PHC'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 Grievance Coordinator will consult with the Grievance Clinical Nurse.
   b. As noted in section I and J, below, the GCN classifies each non-appeal grievance as clinical or non-clinical. The GCN works with the Grievance Coordinator 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 this will be addressed separately, as noted below.
   c. Quality of Care Grievances: The GCN reviews all grievances for potential quality of care issues. If a potential quality of care issue is suspected, the GCN forwards the grievance with supporting documentation to the CMO or physician designee for secondary review. If the CMO or physician designee confirms a potential quality issue, the case is referred to the Patient Safety team within the PHC Quality Department for further investigation as described in MPQP1016. If the physician does not believe a PQI referral is warranted, but the GCN disagrees, the GCN may nonetheless make a PQI referral to the quality department. Quality of care grievances that are found to be without merit by the GCN and the Medical Director are tracked, but not referred to the quality department for further investigation and action.

d. Other clinical issues identified by the GCN may include: access issues, quality of service issues (included alleged discrimination) and quality of facility issues. As the GCN and Grievance Coordinator 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 PHC. Common referrals to other PHC 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 is 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 judgement of the care coordination nurses and managers, such cases may be escalated to department directors or a PHC medical director if 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) Patient safety team within the Quality Department for quality of facility complaints (for example waiting room cleanliness). Depending on the nature of the grievance, the patient safety team may perform a spot check of the facility or ask provider relations to perform a spot check of a facility. If an issue is confirmed, it is addressed as a finding in the context of the site review policy MPQP1022.
   4) Health Education staff within the Population Health Department for accusations of discrimination, lack of translation, or cultural incompatibility. This procedure is described in policy CGA022.
   5) Member Services department management for problems with the initial member services response to grievance.
   6) Compliance department for alleged HIPAA violations or alleged fraud, waste or abuse.
   7) PHC leadership for PHC process issues identified.

e. For standard grievances, responses are recorded and documented in the case management system (Everest). For exempt grievances, responses are also recorded and documented following the standard procedure.

f. PHC receives grievances where 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 PHC staff determines expedited review is needed, the issue will be immediately forwarded to PHC's Medical Directors to render a determination as to whether an expedited review is appropriate. Resolutions on expedited 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 grievance coordinators of the limited time available to present evidence due to the nature of the expedited review request.
2. Expedited Review/Grievance Request Approved
   If PHC's Medical Director determines that the grievance involves an imminent and serious threat to the 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 will notify members verbally that their request for an expedited review has been approved and their case will be processed within 72 hours.
3. Expedited Request Denied
   If PHC'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 request for 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 Resolution Specialist (or designee) will assign the grievance to a grievance coordinator using the Grievance Rotation Tracker.
2. Upon assigning the case, an email is generated to all grievance staff, including the Grievance Clinical Nurse (GCN). The GCN 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 "Clinical vs Non-Clinical" action by the GCN. Grievance staff will utilize the grievance categories worksheet to assess the grievance for other referrals to PHC departments and will proceed as directed in the worksheet.
3. All clinical cases are reviewed by the GCN or designee to evaluate the need to forward the case to the Quality Improvement (QI) Department for a PQI and/or order records for further evaluation. The GCN or designee will direct grievance staff if a PQI referral is needed. The GCN or designee will also make recommendations for case work on any clinical cases.

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

K. Non-Clinical Grievance
A non-clinical grievance is defined as any issue concerning the services provided by PHC and its non-clinical components. The types of grievances considered to be non-clinical in nature include:
1. Billing
2. Benefits/Coverage (benefits)
3. Cultural, Linguistic, and Health Education (by PHC staff, PHC materials)
4. Quality of Service (by PHC 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 PHC clinical staff to assess the member's concern for accuracy. For example, it is not unusual for a patient to feel his/her treatment was incorrect, when in fact it was correct (medical records show that the treatment plan prescribed by the provider is clinically sound).
2. The designated PHC clinical staff will base his/her determination on the review of information submitted by the member or his/her 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 GCL and submitted to the CMO or his/her 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 GCL or Quality Improvement RN, 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 GCN as clinical versus non-clinical and referrals for PQIs are accurately being referred to the QI department, inter-rater reliability studies will be conducted every quarter.
2. Sample will be prepared by the Grievance System 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 his/her 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, clinical or non-clinical was appropriate.
3. Time frame – IRRs will be completed on a quarterly basis and reported to the Member Grievance Review Committee.
4. Results - A 90% inter-rater reliability is required. Where a 90% score is not achieved, additional training will be provided to the GCN by the QI designated staff member and subsequent inter-rater reliability 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 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, PHC will provide to the member the following 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 to mean 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 provide an 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 the treating 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 PHC staff member. PHC staff will assure the member that there will be no discrimination against them by PHC 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 that are issued by grievance staff, the Acknowledgment and Resolution letter. Of note, each member correspondence includes PHC's Nondiscrimination notice and the Your Rights under Medi-Cal Managed Care notice. These notices provide the member information regarding PHC's grievance process including the member's rights to file for a Second Level Grievance or State Hearing if appropriate. 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 5 calendar days of receipt of a grievance. This letter will include the name, address and phone number of the PHC grievance coordinator 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 5 calendar days of receipt, the grievance coordinator will issue only the Grievance Response/Resolution.
      b. Resolution Letter
         1) The grievance coordinator mails a Grievance Response/Resolution within 30 calendar days of the date the grievance was received. The letter summarizes the grievance and describes the resolution. When applicable, the grievance resolution letter will provide Second Level Grievance options. See page 9 for Second Level Grievance definition.

Q. Time Frame - Grievance
   1. Standard:
      a. Resolution – member grievances are resolved within 30 calendar days of the member's request for a grievance [Title 22 CCR 53858 (f) (1)].
   2. Expedited:
      a. Grievance staff will process the case within 72 hours from the date of receipt of the grievance/appeal.
   3. Grievance Acknowledgment will be sent to the member within 5 calendar days of receiving the grievance.

R. Grievance File Maintenance

   Documentation for each grievance is maintained by the Grievance Coordinator. 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 and Frequently Asked Questions about the Grievance Process
      i. Additional written correspondence between PHC, 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

2. Copies of grievances and responses shall be maintained by PHC for ten (10) years. They are maintained on-site for two (2) years, and include a copy of all medical records, documents, evidence of coverage and other relevant information upon which PHC relied in reaching its decision.

S. Second Level Grievance

1. A Second Level Grievance is an appeal of a grievance that has been denied. It provides the opportunity for a different team to investigate the case who were not involved in the original investigation. Examples of denied Second Level Grievances are included, but not limited to:
   a. Denial of a request for transportation due to protocols and/or guidelines
   b. Denial of a request of transportation related to the mode of transportation
   c. Any member dissatisfied with their initial denied grievance resolution
2. A Second Level Grievance will follow standard grievance processing procedures with some exceptions.
   a. The assigned Grievance Coordinator will be new to the investigation and not involved in the original grievance case.
   b. The assigned Grievance Clinical Lead will be new to the investigation and not involved in the original case.
   c. If applicable, the assigned Medical Director will be new to the investigation and not involved in the original case.
   d. PHC will provide language services, bilingual staff or an interpreter, when appropriate.
   e. PHC will re-investigate the substance of the grievance using any additional information provided, along with original case documents and newly requested documents.
   f. PHC will document within the case summary, the substance of the Second Level Grievance and actions taken, including any aspect of clinical care involved.
   g. The Second Level Grievance will follow the standard grievance processing timeframes of 30 calendar days and 72 hours if expedited. The Acknowledgment letter will be sent to the member within five calendar days.
   h. The Second Level Grievance resolution letter may offer information about the State appeal process, if applicable.

VII. MEMBER APPEAL PROCESS

A. 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, his/her authorized representative (AR), or a provider on behalf of a member either orally or in writing. If a member files an oral appeal, the member service representative (MSR) or grievance staff will request the member to provide a written, signed appeal. The oral appeal establishes the filing date of the appeal. There is only one level of appeal for members per 42 CFR 438.402(b).

B. Resolving Member Appeals

1. Confirmation of member appeal
   a. Upon receipt of an appeal, grievance staff conducts a preliminary investigation of the request by identifying 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, PHC staff and any other appropriate individuals to gather

information. Grievance staff will also contact the member to confirm the appeal and to also provide the member an opportunity to submit a statement for the reason for the appeal. When investigating the appeal, PHC 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 14 calendar days to submit the documentation. Upon request, the member has the right to request reasonable access to their appeal case file, including medical records and any other documents before and during the appeal process.
3. Continuation of benefits (also known as aid paid pending)
    a. Upon request, the member's benefit/service can continue pending the outcome of the appeal decision.
        1) The criteria for continuation of benefits is listed below per 42 CFR 438.420
            a) Requests must occur within 10 calendar days from the date the notice of action was mailed to the member.
            b) The appeal must be filed timely.
            c) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
            d) The service was ordered by an authorized provider.
            e) The original period covered by the original authorization has not expired.
            f) The member requests extension of benefits.
    b. Duration of continued or reinstated benefits
        1) If, at the member's request, PHC 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 from the appeal
            b) 10 days pass after PHC mails the notice, providing resolution of the appeal against the member, unless the member, within the 10 day time frame has requested a state hearing with continuation of benefits 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. Examples of Member Appeals
    1. An appeal is a member's request for reconsideration of an initial decision resulting in the denial of service, benefit or claim. Appeals may address, but are not limited to, the following issues:
        a. Appeals of denied Treatment Authorization Requests (TAR)
        b. Appeals of level-of-care determinations
        c. Appeals of PHC 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.

D. 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 to a subordinate of the original 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 his/her expertise or experience, he/she may refer the case to another Medical Director for review (who was not part of the original decision to deny, nor to a subordinate of the original decision maker) or to an outside physician consultant with expertise in this area (Contract Exhibit A Attachment 14, 2, C).

1) Ordering Medical Records
   The Medical Director will direct grievance staff to order medical records from primary care providers and/or other treating physicians if needed. Medical providers are expected to respond to requests for medical records within 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 the final 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 grievance coordinator will make reasonable efforts to notify the member orally and provide written notice within 72 hours.

E. Member Correspondence
1. There are 3 types of member correspondence that are issued by grievance staff. Of note, each member correspondence includes PHC's notice, "Member Complaint, Appeal and Hearing Information". This notice provides the member information regarding PHC's grievance process including the member's rights to file for a state hearing.
   a. Acknowledgment Letter
      1) An acknowledgment letter is issued within 5 calendar days of receipt of an appeal.
      2) This letter will include the receipt date, name, address and phone number of the PHC grievance coordinator 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 5 calendar days of receipt, the grievance coordinator 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, grievance staff 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. Appeal Resolution Letter
      1) For pre service and post service the grievance coordinator 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, including the rationale for upholding the denial 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 PHC (i.e., standard, expedited, extension), the member is considered to have exhausted PHC's appeals process and may proceed to State Hearing.

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

c. Extension Letter

1) In the event an appeal decision cannot be resolved within 30-calendar days and additional information is needed to make a determination, the case may be eligible for a 14-day extension when the delay is in the member's best interest and PHC has the member's consent. When granted, PHC will inform the member of the 14-day extension. PHC will make reasonable efforts to notify the member by phone before the 30th day. PHC will mail a letter to the member on or before the 30th day that clearly states the reason(s) for the extension.

d. Notification

1) Each written notification sent to the member will also include the member's right to file a grievance if the member disagrees with the extension as well a state hearing (Title 22 CCR 53858 (f) (3)].

2) Each notification template (i.e., Notice of Action, 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.

VIII. MEMBER STATE HEARING PROCESS

A. Member State Hearing Timeframe

State Hearings must be filed within 120 calendar days following the date of the Notice of Appeal Resolution (NAR) that is subject of the member's dissatisfaction. State Hearings can be filed by the member or his/her authorized representative (AR). For the purpose of this policy, member will be used to refer to the member and the AR unless otherwise noted.

B. Filing a State Hearing

1. Members have the right to file for a state hearing after exhausting PHC's appeal process.
2. Members can file for a State Hearing with the California Department of Social Services. There are four ways to request a state hearing.

a. By Phone

Members can call the State Hearing Office at 1-800-952-5253. Hearing impaired members may use 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 9-17-37
Sacramento, CA 94244-2430

c. By Fax

Members can fax their hearing request form or their own written request directly to the state at 916-651-5210 or 916-651-2789.

d. In Person

Members can also turn in their hearing request form or their own written request at one of the

local county offices.

C. Responding to State Hearing Requests

1. Notification of Hearing Request
   PHC receives a notice of the member's request for a state hearing from the SCOPE unit in the California 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, PHC staff and any other appropriate individuals to gather information. Grievance staff 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 PHC, staff will offer to open an appeal as well.
3. Parties to State Hearings
   The parties to the state hearings include PHC, the member and their representative or the representative 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 state hearing decision.
   b. The criteria for continuation of benefits is listed below per 42 CFR 438.420.
      1) Request must occur within 10 calendar days from the date the notice of action was mailed to the member.
      2) The state hearing must be filed timely.
      3) The state hearing involves the termination, suspension, or reduction of a previously authorized course of treatment.
      4) The service was ordered by an authorized provider.
      5) The original period covered by the original authorization has not expired.
      6) The member requests extension of benefits.
   c. Duration of continued or reinstated benefits
      If, at the member's request, PHC 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 from 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
   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 review and render a decision if aid paid pending applies.

D. Statement of Position

1. Creation of Statement of Position
   Grievance staff, while working with clinical PHC staff, will prepare the Statement of Position (SOP). The SOP will state the following information:
   a. The Issue
   b. The Background
   c. Pertinent Facts
   d. Guidelines
   e. History of TAR
   f. Applicable Law
   g. Conclusion

2. 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 2 working days prior to the scheduled hearing. To ensure receipt prior to the hearing, PHC will email the statement of position via secure email to scopeofbenefits@dss.ca.gov and the Office of the Ombudsman. Grievance staff will send the Statement of Position via FedEx to the member. FedEx envelops 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.

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

F. Expedited State Hearings
   1. Within 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, PHC will deliver directly to the designated/appropriate DSS Administrative Law Judge, all information and documents which either support, or which PHC 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 Treatment Authorization Request (TAR) and Notice of Action (NOA), plus any pertinent grievance resolution notices. If the NOA or grievance resolution notices are not in English, fully translated copies shall be transmitted to DSS along with copies of the original NOA and grievance resolution notices. 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.

G. State Hearing Decisions
   1. 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 PHC will be noted in the grievance system case file and closed. A copy of the decision is forwarded to the department that rendered the adverse decision to the member.
      b. Overturned Decisions
         Adverse decisions to PHC 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 and will 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 notify that 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.

H. State Hearing File Maintenance
   1. All documentation relating to a state hearing is scanned and uploaded into the grievance system under 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 steps taken to resolve the issue
      b. Notification of State Hearing

c. All written correspondence between PHC, 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

I. Monitoring of Timeliness of Grievances
1. All grievances, appeals and state hearing requests with their resolutions are documented in the grievance system.
2. At the end of each month, the grievance system manager or his/her designee will review the grievance staff cases as part of his/her performance review. In addition, all grievances and appeals that are pending and unresolved for 30 days or more are reviewed
3. Weekly one-on-one meetings are conducted with staff to ensure that member grievances and appeals are resolved within established time frames as well as to review open member grievances and appeals and determine appropriate resolutions.

J. Reporting Grievances to HealthPlan Committees for Review
1. Under the direction and oversight of the Chief Medical Officer (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 PHC 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, PHC's Consumer Advisory Committee (CAC) will review the written record of Grievance and Appeals.

IX. 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 close of the next 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 the close of the next business day, the grievance will remain categorized as "exempt". If the exempt grievance is not resolved by the close of the next 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 Grievance Clinical Nurse (GCN) within 3 days to determine whether the grievance has potential quality of medical care issues. The GCN 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 PHC for UM purposes, care coordination notes and claims history. If the GCN determines a clinical issue identified, they will submit the exempt grievance to the Chief Medical Officer (CMO) or physician designee for review within a timeframe which is appropriate for the nature of the member's condition. Either the GCN or the CMO/physician designee may determine, based on their clinical judgement, that the exempt grievance warrants individual attention by a PHC department, and refer the case for intervention (similar to interventions done for non-exempt grievances, summarized in section G.2.d, above).

X. REPORTING REQUIREMENTS

A. PHC 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 PHC processes.

B. PHC maintains and has available for DHCS' review, PHC's grievance logs, including copies of the grievance logs of any subcontracting entity delegated with the responsibility to maintain and resolve grievances and the PHC exempt grievance log. Grievance logs are maintained based on the requirements set 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 periodically reviewed by PHC. PHC also submits quarterly grievance reports based on Title 28 CCR Section 1300.68(f).

XI. MEDICAL RECORDS/DOCUMENT REQUESTS:

A. Members and providers may call to request materials and/or letters to be sent to them by mail or by fax (upon request).
B. Members can request materials/documents/records free of charge by calling PHC's member services department or by filling out the Grievance Records Request form.

XII. REFERENCES:

A. PHC Contract 08-85215 A19
B. 22 CCR §53858
C. 28 CCR §1300.68 [except subdivision §1300.68(c),(g) and (h)]
D. 28 CCR §1300.68.01[except subdivision §1300.68.01(b)and (c)]
E. 42 CFR 438.420(a)(b) and (c)
F. 42 CFR 438.406(b)(3)
G. APL 17-006 May 9, 2017 Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
H. NCQA2021 Standards and Guidelines: Member Experience 7A-7B
I. NCQA2021 Standards and Guidelines: Utilization Management 8A-9A-9B-9C-9D

XIII. DISTRIBUTION:

A. PHC Department Directors
B. PHC Provider Manual

XIV. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Grievance & Appeals Manager

XV. 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

PREVIOUSLY APPLIED TO: N/A