PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

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<tr><td colspan="4">Policy/Procedure Number: MPPRGR210</td><td colspan="3">Lead Department: Provider Relations</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Provider Grievance</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/25/1994</td><td colspan="4">Next Review Date: 10/14/2027
Last Review Date: 10/14/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="2">☐ Partnership Advantage</td><td colspan="2">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td><td></td></tr>
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<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>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 10/14/2026</td></tr>
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I. RELATED POLICIES:

A. MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions
B. MPQP1053 – Peer Review Committee
C. MPQP1016 – Potential Quality Issue Investigation and Resolution
D. CGA024 – Medi-Cal Member Grievance System
E. CLPM-41 – Claims Provider Dispute Resolution Mechanism
F. CMP38 – Escalation and Corrective Action

II. IMPACTED DEPTS:

A. All Departments

III. DEFINITIONS:

A. Network Provider: any Provider or entity that has an Agreement with Partnership and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services to Partnership members.
B. Provider Dispute Resolution (PDR): the process by which a provider's written notice to the plan challenging, appealing or requesting reconsideration of a claim that has been denied, adjusted or contested or seeking resolution of a billing determination or disputing a request for reimbursement of an overpayment is resolved
C. Provider Grievance: a formal written expression of dissatisfaction submitted by a Network Provider related to Partnership's policies, processes, procedures, or administrative actions, with the exception of decisions regarding claims or service authorizations. A provider grievance may be submitted after any applicable Partnership reconsideration, appeal, or dispute resolution processes have been exhausted.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

This policy establishes the process by which Network Providers may submit, and Partnership HealthPlan of California (Partnership) may review and resolve provider grievances. This policy applies to provider grievances that are not member grievances or member appeals and does not replace or supersede the Utilization Management/Pharmacy appeals or Medi-Cal Member Grievance processes. This policy is also separate from the Provider Dispute Resolution (PDR) process. Claims payment disputes, overpayment disputes, and other claim- related matters must first be addressed through the PDR process and are not eligible for review through the Provider Grievance process unless all applicable PDR processes have been exhausted. Providers not contracted with Partnership are not eligible to submit provider grievances.

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Policy/Procedure Title: Provider Grievance			☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/25/1994			**Next Review Date: 10/14/2027** **Last Review Date: 10/14/2026**
Applies to:	☒ **Medi-Cal**	☐**Partnership Advantage**	☐ **Employees**

VI. POLICY / PROCEDURE:

A. The Partnership HealthPlan of California, Chief Executive Officer is ultimately responsible for the provider grievance process and has primary responsibility for maintenance, review, formulation of policy changes and procedural improvements of the grievance review system. The CEO is assisted by the Partnership Chief Medical Officer, Chief Health Services Officer, Chief Operating Officer, and Director of Provider Relations. The provider grievance process is managed and monitored by the Provider Relations department.

B. INTAKE:

1. Informal complaints and requests for routine assistance are addressed by the Provider Relations team, with assistance from other staff as needed. Formal written acknowledgements or resolutions are generally not necessary for these matters but are available if requested.
    a. Provider concern(s) should first be addressed through the impacted department's internal resolution policies and procedures. The Provider Relations team will connect the caller to the appropriate department to address the issue and respond appropriately.
2. If unable to resolve, upon receipt, Provider Relations shall review and categorize the grievance to determine:
    a. Appropriate internal routing
    b. Level of urgency
    c. Required escalation
    d. Applicable resolution timeframe
3. Providers have 180 calendar days from the incident date to report any concerns to the Provider Relations team via the Provider Grievance Intake form or formal written notice to prgrievances@partnershiphp.org.

C. REVIEW/RESOLUTION

1. Provider Grievances shall be resolved within sixty (60) business days.
    a. If a provider submits a formal written grievance, Provider Relations team shall acknowledge receipt of a provider grievance within five (5) business days of submission.
    b. If the Provider Relations team is unable to adjudicate the grievance within thirty (30) business days, the grievance may be submitted to the executive committee for final review.
    c. The Executive Committee will review and determine final decision of the grievance within fifteen (15) business days of the escalation.
    d. The provider is formally notified within fifteen (15) business days of the Committee's decision.
2. Partnership shall make reasonable efforts to resolve grievances at the lowest appropriate level and within the shortest timeframe practicable.
3. If during the review process, it is determined that a provider may be deficient in rendering or managing care, or problem areas are discovered, a Potential Quality Issue (PQI) referral is made to the Quality Improvement (QI) department via the PQI Referral Intake System. See MPQP1016 - Potential Quality Issue Investigation and Resolution.
4. The plan or the plan's capitated provider shall not discriminate or retaliate against a provider (including but not limited to the cancellation of the provider's contract) because the provider filed a provider grievance.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates (*revised* Aug. 31, 2022, *supersedes* APL 17-006)

B. National Committee for Quality Assurance (NCQA) Guidelines (effective July 1, 2026) UM 7 Element C, Written Notification of Non-Behavioral Healthcare Appeal Rights/Process

C. DHCS All Plan Letter (APL) 26-006 Skilled Nursing Facility Workforce Quality Incentive Program

(March 30, 2026)

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

IX. DEPARTMENT RESPONSIBLE FOR IMPLEMENTING PROCEDURE:

Director of Provider Relations

X. REVISION DATES:

Medi-Cal: 08/23/1996, 10/10/1997, 03/29/2000, 07/24/2000, 09/13/2000, 07/17/2002, 11/17/2003, 2/11/2004,02/09/2005, 03/08/2006, 07/11/2007, 03/12/2008, 04/08/2009, 07/08/2009, 08/11/2010, 08/10/2011,08/08/2012, 08/14/2013, 08/13/2014, 08/12/2015, 08/10/2016, 08/09/2017, 08/08/2018, 01/09/2019,01/08/2020, 08/12/2020, 08/11/2021, 08/10/2022, 08/09/2023, 08/14/2024, 04/08/2026, 10/14/2026

PREVIOUSLY APPLIED TO:

N/A

REGULATOR APPROVAL: