

SAN FRANCISCO HEALTH PLAN

Member Grievances and Appeals

POLICY STATEMENT

San Francisco Health Plan (SFHP) encourages its members to voice their grievances and appeals. The SFHP grievance process is designed to address and resolve these member concerns in a manner that is accessible, timely and thorough.

DEFINITIONS

1. "Grievance" means any written or oral expression of dissatisfaction, complaint, dispute, or request for reconsideration made by an enrollee or the enrollee's representative to the Plan or to any entity with delegated authority to resolve grievances on behalf of the Plan.
2. "Complaint" is the same as "grievance."
3. "Appeal" is a request to reconsider an initial grievance decision.
4. "Expedited review" is an accelerated review and reporting process for grievances involving an imminent and serious threat to the member's health.
5. An "imminent and serious threat to health" includes, but is not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the member.
6. "Independent medical review" (IMR) is the expert review of disputed health care services by an outside organization that contracts with the Department of Managed Health Care (DMHC).
7. A "disputed health care service" is any health care service that is eligible for coverage and payment by the Plan or medical group that has been delayed, denied or modified by a decision of the Plan or one of its medical groups. The decision to delay, deny or modify must be made, in whole or in part, due to a finding that the service is not medically necessary. A decision regarding disputed health care services relates to the practice of medicine and is not a coverage decision.

SCOPE

The basic grievance process described in this policy and procedure is available to all SFHP members. This policy also includes specific processes that are available only to Medi-Cal beneficiaries. Additional policies govern the Plan's utilization management process, including the process for initially denying, delaying or modifying health care services. The grievance process is used when a member elects to dispute a utilization management decision, or to express any other form of dissatisfaction.

MEMBER RIGHTS

1. A member has the right to file a grievance at any time for any reason. San Francisco Health Plan does not discriminate against a member, or disenroll a member because he/she files a grievance.
2. A member has a right to continuous medical care. A SFHP practitioner cannot withhold or terminate care because a member has filed a grievance.
3. A member has the right to have a representative, an advocate and/or lawyer assist in the grievance process.
4. A member has the right to propose a solution to a grievance.

CULTURAL AND LINGUISTIC REQUIREMENTS

A member has the right to language translation during any part of the grievance process. Standard documents and correspondence are available in threshold languages. SFHP's policies, Use of Interpreter Service and Bilingual Staff and Translation of Member Materials, detail SFHP's system for addressing cultural and linguistic requirements. Use of these policies assures that the grievance process is accessible and fair to all members.

MEMBER INFORMATION

SFHP assists its members to understand and use all internal and external grievance and appeal processes available to them. It provides all members access to comprehensive, accurate and easily understood information about the grievance and appeals procedure. The procedure is published in the Member Handbook. At minimum, the following information is included:

1. how to file a grievance, by phone or in person, verbally or in writing, by contacting the primary care practitioner's office, the medical group or San Francisco Health Plan
2. how to appeal a grievance determination
3. how to contact the SFHP Member Services Department for assistance in the grievance process, to find an independent advocate, to access translation services or for any other reason
4. how to request an expedited medical review
5. how to contact the DMHC, using the toll-free telephone number, the telephone number for relay services provided for the hearing and speech-impaired, and the website. A separate SFHP policy governs independent medical review.
6. For Medi-Cal beneficiaries: how to request a State Fair Hearing and how to reach the Ombudsman, using toll-free and TDD phone numbers.

PRACTITIONER INFORMATION

SFHP informs its providers about grievance and appeal procedures through the Provider Operations Manual. SFHP distributes Grievance Forms (attached) in the required threshold languages to all primary care and medical group offices.

SFHP MEMBER SERVICES DEPARTMENT

The San Francisco Health Plan Member Services Department is responsible for all member contact. Whenever any issue arises that is, in any part, an expression of dissatisfaction, Member Services agents fill out an intake form (attached). The intake form documents that a grievance has been voiced and needs resolution through the grievance process. An issue that is an "imminent and serious threat to health" is brought to the immediate attention of the SFHP Medical Director. The intake form includes a description of the problem, a summary of what the Member Services agent told the member, and information about how to reach the member within the next hour, if needed. The Member Services Department refers members with grievances involving carved out services to the appropriate agency.

HOW A MEMBER FILES A GRIEVANCE

The SFHP Member Services Department ensures that members have the opportunity to fully express a grievance.

1. Members or their representatives may file a grievance with the SFHP Member Services Department by mail, fax, email, in person, or through our website.
2. The medical group staff and providers may refer the member to the SFHP Member Services Department and/or directly assist the member to file a grievance by phone.

3. The member and/or the member's representative may complete a SFHP Grievance Report and submit it to the SFHP Member Services Department. Grievance Reports are available in threshold languages through the SFHP Member Services Department (by mail, fax, email, in person, or on our website) and in all primary care and medical group offices. A member's signature is not required.

GRIEVANCE PROCESS

1. The SFHP Member Services Department is available to assist the member throughout the grievance process.
2. 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 exempt from the requirement to send a written acknowledgement and response. These grievances are still entered in the log.
3. Except as described in #2 above, a written acknowledgement letter is provided within five calendar days of receipt. This acknowledgement advises the member that the grievance has been received, the date of the receipt, and provides the name, telephone number and address of the SFHP Grievance Coordinator. The letter, at minimum, contains all the components and information included in the *acknowledgement letter template* attached to this policy.
4. The SFHP Grievance Coordinator reviews all grievances with staff responsible for the areas of service that are subject to the grievance, and consults as needed with the member and/or the member's representative, the member's practitioner, and/or medical group staff.
5. The Grievance Coordinator issues a written resolution to the grievance and mails it to the member within 30 calendar days of receipt, except as described in #2 above. The written response contains a clear and concise explanation of the plan's decision. The letter also contains all the components and information included in the *resolution letter template* attached to this policy. The resolution letter is timed to allow sufficient time for an appeal, if the member requests it, within the 30 days period.
6. SFHP, medical group staff and committee members who assist in the grievance process agree to strict standards of confidentiality.
7. SFHP stores all grievance files and logs in a secure location for at least five years.
8. If a member requests an appeal, the procedure for an appeal is initiated. Please refer to the Appeal Process section.

MEDICAL AND NON-MEDICAL GRIEVANCES

Any member grievance that could involve a clinical issue is referred by the Grievance Coordinator directly to clinical staff for review. If clinical staff determines that the issue is non-clinical, it is referred back to the Grievance Coordinator for resolution.

Every grievance is resolved as expeditiously as the member's health condition requires. An issue that is an "imminent and serious threat to health" is brought to the immediate attention of the Medical Director. The SFHP Medical Director determines if a grievance qualifies for expedited review and investigates the issue through discussion with the involved practitioners, medical record review or other means. The SFHP Medical Director establishes an appropriate procedure and timeline.

Appropriate issues to refer to clinical staff include:

1. delay, modification or denial of a requested health care services
2. patient disagrees with provider's treatment

3. patient disagrees with diagnosis
4. alleged failure or refusal by a practitioner to refer
5. unavailability of practitioner (during and after-office hours)
6. practitioner does not provide alleged covered and medically necessary service
7. alleged adverse results of treatment
8. alleged refusal or delay in providing services or treatment
9. alleged inappropriate practitioner behavior
10. other issues that are judged to be clinical in nature.

Clinical staff bring every grievance that potentially involves a quality of care issue to the Medical Director for review. The Medical Director verifies the determination in the grievance file and assures appropriate follow-up action.

GRIEVANCES OF DISPUTED HEALTH CARE SERVICES

1. The Grievance Coordinator sends the member an acknowledgement letter. If a proposed resolution is available within this timeframe, it is included in the letter and it becomes an Acknowledgement and Resolution letter. The letter, at minimum, contains all the components and information included in the *acknowledgement letter template* attached to this policy.
2. The SFHP Medical Director reviews the initial decision to deny, defer or modify care and may support or overturn it.
3. A resolution letter is sent to the member. The letter offers the member an appeal hearing. The letter also contains all the components and information included in the *disputed health care services resolution letter template* attached to this policy.
4. If the member accepts the resolution, the case is closed. If the member does not respond, the case is closed in 30-calendar days. If the case is closed without a member response, the member may contact the plan and reactivate the grievance within six months. If the member requests an appeal, the procedure for an appeal is initiated, using the attached *hearing letter template*.

EXPEDITED REVIEW

When grievances of disputed health care services involve a serious and imminent threat to the health of the member, the grievance process is expedited, and the clinical status of the patient is monitored throughout the process and acts as expeditiously as the member's health requires. The total time permitted for an expedited review is three-calendar days.

{A Medi-Cal member may bypass the Plan's grievance process and apply for an expedited State Fair Hearing. The member may also file for an expedited State Fair Hearing concurrently with using the Plan grievance process. If the Plan fails to resolve an expedited issue in 72 hours or its resolution is wholly or partially adverse, the member may also file. SFHP or the member's provider will provide documentation supporting the need for an expedited hearing. SFHP responds within two business days to requests for documents pertinent to the expedited hearing and assigns a representative to participate.}

1. The Grievance Coordinator informs the member of his/her right to concurrently notify the DMHC about the grievance, and provides the member with all information contained in the notice for "Filing a Grievance with the DMHC." The initial notification need not be in writing and can be accomplished by a documented telephone call. The Grievance Coordinator also mails an acknowledgement letter that contains all the components and information included in the *acknowledgement letter template* attached to this policy.

2. The Grievance Coordinator marks the grievance log to indicate an expedited review, and documents the date and time of each action taken.
3. The expedited review is initiated immediately upon receipt, and is resolved as soon as possible. The period from grievance to resolution does not exceed three-calendar days. The member and practitioner are informed of the resolution immediately, by phone or fax, and a written resolution letter follows.
4. The Grievance Coordinator sends a resolution letter regarding the disposition or status of the grievance no later than three-calendar days after the grievance is filed. The letter is sent to the member and the practitioner. The letter, at minimum, contains all the components and information contained in the *disputed health care services resolution letter template* attached to this policy.

APPEAL HEARING

1. SFHP addresses a member's appeal at a hearing. The SFHP CEO identifies an Appeal Hearing Coordinator and convenes the hearing committee that is comprised of:
 - the SFHP CEO
 - a SFHP beneficiary that serves on the SFHP Quality Improvement Committee or Governing Board
 - a member of the Governing Board
 - when the hearing involves a disputed health care service, a physician who typically treats the health condition that is at issue, and who has not previously reviewed the issue joins the committee as a voting member.
2. The SFHP Medical Director or any staff member who reviewed the initial determination, may address the hearing, but may not vote.
3. The Appeal Hearing Coordinator invites the member and/or the member's representative to attend the hearing. The Appeal Hearing Coordinator informs the member and/or the member's representative about these rights:
 - to meet with a Plan representative at least five-business days before the hearing to discuss the case and review related documents
 - to obtain a copy of the Plan's grievance and appeal policies
 - to obtain a copy of medical files, and the criteria used to authorize, deny or modify a health care service.
 - to obtain language translation, transportation and other forms of assistance to facilitate participation in the hearing
 - to participate in the hearing in person or by phone, present evidence and witnesses, and question witnesses presented by SFHP. The hearing is scheduled to facilitate member participation.
4. The Appeal Hearing Coordinator mails the member a final resolution letter within five-business days after the hearing. The letter, at minimum, contains all the components and information included in the *final resolution letter template* attached to this policy. If the grievance involved a disputed health care service, information about the IMR process and related documents are included with the final resolution letter.

GRIEVANCE LOG

The SFHP Grievance Coordinator logs member grievances in the grievance database, which records at minimum the following information:

1. the date and time the grievance is filed

2. the name of the member filing the grievance and the person representing the member
3. the name of the plan provider or staff person receiving the grievance
4. a description of the grievance
5. a code for tracking the grievance by category (attached)
6. information regarding physical or language requirements that are relevant to ongoing communication with the member or the member's representative
7. a description of all actions taken to investigate and resolve the grievance and the dates the actions were taken
8. the proposed resolution
9. the date that the member is notified of the proposed resolution
10. a dated record of all member contacts.
11. the name of the person responsible for resolving the grievance
12. the date that the issue is resolved.

GRIEVANCE FILE

The Grievance Coordinator maintains a grievance file that contains all evidence collected while investigating the grievance, including medical records, evidence of coverage and other documents relevant to the grievance determination, and copies of all correspondence.

FILING A GRIEVANCE WITH THE DMHC

A SFHP member may file a grievance with the DMHC after completing the Plan's process or after participating for 30-calendar days. An earlier review may be allowed in expedited situations.

1. SFHP includes the following language in all correspondence related to the grievance and appeal process and in SFHP's Member Handbook:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1 (800) 288-5555 or (415) 547-7800** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online."
2. When SFHP receives notification that a member has filed a grievance with the DMHC, it submits a response and copies of relevant documents from the Plan grievance file, including all related medical records and the applicable evidence of coverage within five-business days of the request.
3. Upon receipt of a DMHC grievance determination, SFHP acts to implement the decision within the deadlines set by the DMHC.

STATE OMBUDSMAN OFFICE

SFHP informs Medi-Cal beneficiaries in their Handbook, and in all correspondence regarding the grievance and appeal process that they may call the State Ombudsman for help with a grievance. The Ombudsman Office is reached toll-free at 1-888-452-8609. The TDD number is 1-800-952-8349. Its office hours are Monday-Friday, 8 a.m. to 5 p.m., closed on State holidays.

STATE FAIR HEARING

SFHP informs Medi-Cal beneficiaries in their Member Handbook, and in all correspondence regarding the grievance and appeal process that, in addition to the Plan grievance process, they may request a State Fair Hearing.

1. The member or the member's representative is informed that:
 - Information regarding the State Fair Hearing process is available by writing the California Department of Social Services (CDSS), State Hearing Division, PO Box 944243, MS 19-37, Sacramento, CA, 94244-2430, or by calling 1-800-952-5253. The TDD number is 1-800-952-8349.
 - The SFHP Customer Service Department will provide State Fair Hearing request forms. Forms are also available through the San Francisco Department of Social Services.
 - The member or the member's representative may chose to be represented by a friend, an attorney, or another person at the State Fair Hearing. To find out about free legal assistance, the member may call the toll-free number of Public Inquiry and Response Unit at 1-800-952-5253.
 - The member or the member's representative may call the State Ombudsman for help. The Ombudsman Office is reached toll-free at 1-888-452-8609. The TDD number is 1-800-952-8349, Monday-Friday. Its hours are 8 a.m. to 5 p.m., closed on State holidays.
 - The member or the member's representative must request the hearing within 90 days of an action to delay, defer or modify health care services. When a member files for a hearing within 10 days of a notice to delay, modify or deny medical services, current services will be authorized until a State Fair Hearing decision is made.
 - The member or the member's representative may examine the materials that make up the record for the State Fair Hearing decision, and may locate the record by contacting the Public Inquiry and Response Unit at 1-800-952-5253.
 - Any information that the member provides for a hearing may be shared with the county Department of Social Services or with the United States Department of Health and Human Services.
2. When SFHP receives notification that a member has requested a State Fair Hearing, it prepares a position statement. A copy of the position statement is sent to the member, to the Office of the Ombudsman, MMCD, 714 P Street, Room 677, Sacramento, CA 95814; and to CDSS, State Hearing Division, PO Box 944243, MS19-37, Sacramento, CA. The Plan submits its position statement at least five-business days prior to the date of the hearing.
3. When a finding on the final disposition of the case is received from the State Fair Hearing Officer, SFHP acts to implement the order within the deadlines set by the order. If the issue is a medical service, it is authorized within five-business days, or sooner if medically indicated. If the service has already been rendered, any outstanding claims are reimbursed within five-business days.

THE MEDICAL GROUP'S ROLE

1. SFHP relies on its medical groups to encourage SFHP members to voice any expression of dissatisfaction directly to SFHP and to work with the Plan to resolve grievances as quickly and as fairly as possible.
2. Medical groups and primary care providers must know how to assist members in the SFHP grievance process and have SFHP Grievance Forms available.
3. When a member expresses any form of dissatisfaction, the medical group staff and providers must give the member a SFHP Grievance Form, and offer assistance to submit it. They may also advise the member to contact SFHP's Member Services Department by any method. They may directly assist the member to file a grievance with the SFHP Member Services Department by phone.
4. Medical groups and providers must also assist in the review and resolution of member grievances. This process includes retrieving medical records and providing any other information necessary to resolve the grievance.
5. The medical group assures that the member receives continuous medical care during the grievance process.
6. Medical groups and providers must take corrective action as determined by a member grievance resolution and address systemic issues identified in the grievance process.

DELEGATION

1. SFHP delegates the grievance process to Kaiser Health Plan
2. SFHP oversees the delegation of the grievance process that is conducted by Kaiser Health Plan through quarterly reviews of Kaiser's grievance log and annual audits.
3. SFHP requires corrective action whenever it identifies a problem in Kaiser Health Plan's grievance process, and assigns a deadline for receiving evidence that the problem has been resolved. For serious or persistent problems, SFHP may require that Kaiser Health Plan refer all member grievances directly to SFHP for resolution.

QUALITY IMPROVEMENT COMMITTEE OVERSIGHT

1. The SFHP Governing Board oversees the grievance process. The SFHP Member Services Director is responsible for maintaining grievance procedures, reviewing the operation of the process, and leading the Plan's quality committees in identifying emergent patterns of grievances in order to initiate systemic improvements in Plan operations.
2. SFHP quality improvement committees assure that grievances and appeals are addressed in a manner that is accessible, timely and thorough. The quality improvement process is used to examine individual grievances and grievance trends in order to establish priorities for improvement and to implement appropriate improvement actions.
 - The Grievance Coordinator oversees the maintenance of the grievance log and the preparations of grievance reports. The report highlights grievance trends by category, line of business and medical group. It identifies all grievances that have not been resolved within specified time frames.
 - The Quality Management Team reviews quarterly grievance reports. It may act to improve the quality and efficiency of the process, or to initiate improvement activities that directly address the issues raised.
 - The Quality Improvement Committee reviews trended grievance information, and receives reports from the Grievance Coordinator. It may act to improve the quality and efficiency of the process, or to initiate improvement activities that

directly address the individual or systemic issues raised. The Quality Improvement Committee reviews all grievance and appeal policies.

- At least quarterly, the Governing Board reviews the activities of all quality committees. Annually, the Governing Board reviews the Quality Improvement Evaluation, which includes tabulated grievance data, an evaluation of grievance and complaint trends, member satisfaction survey results and related data. The Quality Improvement Evaluation also proposes priority areas for improvement, and related activities and goals. The Governing Board may direct the Plan to improve the quality and efficiency of the grievance process, or to initiative improvement activities that directly address the individual or systemic issues raised.

ATTACHMENTS

1. SFHP Complaint Report
2. Customer Service Intake Form
3. Complaint and Grievance Codes
4. SFHP Grievance Log
5. Acknowledgement Letter Template
6. Disputed Health Care Service Resolution Letter Template
7. Non-Medical Resolution Letter #1 Template
8. Non-Medical Resolution Letter #2 Template
9. Hearing Letter Template
10. Final Resolution Letter Template

REFERENCES

1. MMCD All Plan 03009: Expedited State Hearings
2. MMCD All Plan 03008: Submission of Quarterly Logs
3. Title 28, California Code of Regulations, Section 1300.68
4. Title 22, California Code of Regulations, Section 53858, 53893, 51014
5. Health and Safety Code, Sections 1367.01, 1368, 1368.01, 1368.03, 1368.04, 1370.4, 1374.30, 1374.31, 1374.32, 1374.33, 1374.35, and 1374.36
6. Welfare and Institutions Code 10961

RELATED POLICIES

1. Independent Medical Review
2. Oversight of Kaiser Health Plan
3. Use of Interpreter Service and Bilingual Staff
4. Translation of Member Material
5. Hearing Committee When a Member Appeals a Grievance