SAN FRANCISCO HEALTH PLAN

SFHP POLICY AND PROCEDURE

Clinical Member Grievances

Policy and Procedure Number:	**QI-06**
Department Owner:	**Health Outcomes Improvement**
Lines of Business Affected:	**Medi-Cal, Healthy Workers HMO, Healthy Kids HMO**

POLICY STATEMENT

San Francisco Health Plan (SFHP) responds to all member expressions of dissatisfaction communicated to SFHP. Our highest priority is to resolve every concern or dissatisfaction wherever members receive care. Clinical Grievances are expressions of dissatisfaction by members about any issue concerning the care and services provided by SFHP's provider network and its clinical components. SFHP's Health Outcomes Improvement (HOI) department addresses and resolves members' Clinical Grievances in a timely, fair and thorough manner. SFHP's Clinical Grievance process complies with applicable federal and state laws and regulations as well as applicable requirements in SFHP's Medi-Cal contract with the Department of Health Care Services (DHCS).

PROCEDURE

I. SCOPE

A member has the right to file a Grievance for any reason that is not about an Adverse Benefit Determination (Notice of Action) and not about a SFHP decision to deny, delay or modify a health care service. Grievances are also known as Administrative Appeals. This policy and procedure describes HOI Department processes to investigate and resolve Clinical Grievances. A Clinical Grievance is any issue concerning the services provided by a clinic, hospital, provider or pharmacy. Clinical Grievances require licensed health professional review. Types of Clinical Grievances include, but are not limited to:

- Quality of service (by clinic/hospital/provider)
- Access
- Pharmacy issues
- Quality of medical care
- Denials and/or refusals (formulary, denial of service/treatment)
- Cultural, Linguistic, and Health Education (by clinic/hospital/provider)

Refer to policy CS-13 for procedures relevant to member rights, intake of member expressions of dissatisfaction, case creation, and Grievance classification. Refer to CS-14 for procedures relevant to the handling and resolution of Non-Clinical Grievances.

Refer to QI-17 for procedures relevant to Adverse Benefit Determinations and decisions by SFHP to deny, delay or modify health care services.

II. Standards for Processing Clinical Grievances

a. Filing Timeframes

1. Medi-Cal members may file a Clinical Grievance at any time.
2. Healthy Workers HMO and Healthy Kids HMO members may submit a Clinical Grievance within 180 calendar days of any incident or action that is the subject of the member's dissatisfaction.

b. Intake

Pursuant to CS-13, SFHP Customer Service performs intake of Grievances, including Appeals, entry of complaints in SFHP's Care Management System, and provides immediate notification of the right to contact the Department of Managed Health Care (DMHC), including the DMHC phone number, to members requesting Expedited Review of complaints.

c. Triage

1. SFHP Customer Service Representatives direct all Grievances and Appeals to the HOI Quality Review (QR) RN. Within one (1) business day of receipt, the HOI QR RN determines whether the complaint:
    i. Is an Appeal or Grievance,
    ii. Involves clinical or non-clinical issues (complaints involving both clinical and non-clinical issues will be classified as clinical),
    iii. Meets Expedited Review criteria (i.e., involves a serious and imminent threat to the health of the member including, but not limited to, severe pain, potential loss of life, limb or major bodily function),
    iv. Involves services already rendered,
    v. Involves any Potential Quality Issues (PQIs),
    vi. Is related to any Carved Out Services, and
    vii. Is related to Other Health Coverage (e.g., Medicare benefits for Dual-Eligible Members).

2. HOI QR RN considers the member's medical condition when determining SFHP's response time. See section E. Acknowledgement and H. Expedited Clinical Grievances, for more details on handling of Expedited Clinical Grievances.

3. The HOI QR RN, Customer Service Grievance Coordinator, and/ or HOI/Access and Care Experience (ACE) Grievance Coordinator may contact the member to obtain additional information needed to process the Grievance.
4. HOI QR RN conducts an initial case category determination for all Clinical Grievances and routes the case to the HOI Grievance Analyst, or designee.
5. HOI Grievance Analyst, or designee, assigns the Grievance to a HOI Grievance Coordinator/Specialist.
6. HOI QR RN works with the assigned HOI Grievance Coordinator to resolve the Clinical Grievance.
7. Grievances related to medical quality of care issues or PQIs are described in QI-18.

d. Documentation

1. SFHP's Care Management System case notes and attachments store documentation and actions taken to address the Clinical Grievance. Hard copy files may be printed from SFHP's Care Management System.
2. SFHP maintains a written record for each Clinical Grievance received, including:
    a. Date and time of receipt
    b. Name of member filing the Grievance and any authorized representatives
    c. SFHP representative recording/intaking the Grievance
    d. Description of the complaint or problem
    e. Name of the SFHP staff responsible for resolving the Grievance
    f. Date acknowledgement notification sent to the member
    g. Description of the action taken by SFHP to investigate and resolve the Grievance
    h. Proposed resolution by SFHP
    i. Date resolution notification sent to the member
3. The HOI Grievance Coordinator ensures documentation of all findings, including clinical review, is entered in SFHP's Care Management System.
4. Standard documents and correspondence are available in the Medi-Cal, Healthy Workers HMO, and Healthy Kids HMO threshold languages in accordance with the member's written and spoken language.
5. Grievance notices are based on templates reviewed and approved by DHCS and DMHC. Please reference Appendix A for a list of SFHP's Grievance notices and the enclosures sent with each notice.
6. A member has the right to interpreter services during any part of the Grievance process. SFHP provides access to telephone relay systems and other devices that aid disabled individuals to communicate. SFHP's policy, CLS-02, details SFHP's system for addressing cultural and linguistic requirements.

e. Acknowledgement

Unless otherwise specified, the following requirements apply to both standard and expedited Clinical Grievances:

1. Except for Expedited Clinical Grievances, the HOI Grievance Coordinator sends an Acknowledgement Letter within five (5) calendar days of receipt of the Grievance.
2. The Acknowledgement Letter advises the member that the grievance has been received, the date of the receipt, and the name, telephone number and address of the HOI Grievance Coordinator.
3. Acknowledgement Letter notices are based on templates reviewed and approved by DHCS and DMHC.
4. The Acknowledgement Letter informs the member that they may submit additional information or documentation supporting their Clinical Grievance.
5. If an Expedited Review is requested and the issue(s) do not meet criteria for Expedited Review, the HOI QR RN or HOI Grievance Coordinator make reasonable attempts to provide oral notice to the member that the Grievance will be processed within the standard timeframe of 30 calendar days from receipt. This is done within five (5) calendar days of receipt of the Grievance.
    a. The member is informed of the right to concurrently notify the DMHC about the Grievance, and provides the member with DMHC's contact information.
    b. The member is informed of their right to file a Grievance if they are unhappy with the decision to downgrade the grievance from expedited to standard timeframe for investigation.
    c. Within five (5) calendar days of receipt of the Clinical Grievance, the HOI Grievance Coordinator sends the Member an Acknowledgement Letter informing the member their Grievance was received, that the Grievance was downgraded to a standard Grievance, and will be resolved within 30 calendar days ("Downgrade Acknowledgement Letter").
6. All Acknowledgement Letters include:
    a. Paragraph required by Health & Safety Code Section 1368.02, which provides information about how to contact the Department of Managed Health Care (DMHC) for further external review of the Grievance by the DMHC.
    b. For Medi-Cal members, the State Ombudsman's office contact information. 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, 8am to 5 pm, closed on State holidays.

f. Investigation

Unless otherwise specified, the following requirements apply to both standard and expedited Clinical Grievances:

1. The HOI Grievance Coordinator investigates the substance of the Clinical Grievance, under the supervision of the Access and Care Experience (ACE) Manager, QR RN, and Grievance Review Committee (GRC).
2. HOI QR RN, or designee, recommends and/or approves investigation questions related to quality of care concerns.

3. For Grievances that do no not involve quality of care concerns, the HOI Grievance Coordinator develops investigation questions.
4. HOI Grievance Coordinator sends investigation questions to the provider and/or medical group involved in the Grievance to ensure all member concerns addressed.
    a. Medical group staff and providers are required to 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.
    b. The provider and medical group assures the member receives continuous medical care during the grievance process.
5. HOI Grievance Coordinator documents investigation outcome.
6. HOI Grievance Coordinator presents Grievance to the GRC to ensure all components of the Grievance have been fully investigated, including any aspects of clinical care involved, and to determine if the Grievance can be closed or if additional follow up is needed.

g. Resolution

Unless otherwise specified, the following requirements apply to both standard and expedited Clinical Grievances:

1. The Clinical Grievance is Resolved when the grievance has reached a conclusion with respect to the member's submitted Grievance, and there are no pending member Grievances within SFHP's Grievance system, including entities with delegated authority.
2. The disposition of the Clinical Grievance is communicated through the Grievance Resolution Letter.
3. The HOI Grievance Coordinator drafts the Grievance Resolution Letter, which includes a description of the substance of the Clinical Grievance and a Clear and Concise explanation of the findings and SFHP's decision.
4. If the member presented multiple issues, the resolution addresses all issues.
5. ACE Manager, or designee, reviews and approves the Grievance Resolution Letter to ensure it reflects decisions made by SFHP's Medical Director, is Clear and Concise, and responsive to the member's desired resolution.
6. SFHP's timeliness and notification standards consider clinical urgency. The HOI Grievance Coordinator ensures the case is resolved within the required timeframe.
7. For non-expedited Clinical Grievances, the HOI Grievance Coordinator mails the Grievance Resolution Letter to the member within 30 calendar days of receipt of the Clinical Grievance.
8. Grievance Resolution Letter includes:
    a. Paragraph required by Health & Safety Code Section 1368.02, which provides information about how to contact the DMHC for further external review of the Grievance by the DMHC.
    b. For Medi-Cal members, the State Ombudsman's office contact information.

9. HOI Grievance Coordinator sends correspondence to the member with all required attachments or enclosures. (See Appendix A: Letter Type and Required Attachments).
10. If resolution cannot be provided within the required timeframe, the Grievance Coordinator makes reasonable efforts to contact the member by the Grievance due date to notify them of their right to contact DMHC and pending status of the grievance investigation and resolution.

h. Expedited Clinical Grievances

The following requirements apply to Expedited Clinical Grievances only:

1. Per the Triage portion in this policy, HOI QR RN determines that a Clinical Grievance requires Expedited Review if it involves an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function.
2. Per the Triage portion in this policy, members requesting Expedited Review of a Grievance are immediately informed of the right to contact the DMHC about their Grievance.
3. Expedited Clinical Grievances are tracked and documented in SFHP's Care Management System.
4. The total time permitted to close an expedited Grievance is 72 hours from the date and time of Grievance receipt.
5. HOI Grievance Coordinator investigates the Clinical Grievance under the supervision of the HOI QR RN and ACE Manager.
6. HOI Grievance Coordinator consults with other staff responsible for the areas of service related to the Clinical Grievance, as needed.
7. The HOI Grievance Coordinator communicates the disposition of the Clinical Grievance to the member, a provider acting on behalf of the member, or an authorized representative via telephone and in writing (Grievance Resolution Letter) within 72 hours of receipt of the Clinical Grievance.
8. The HOI Grievance Coordinator notifies the Supervisor, Regulatory Affairs, or designee, of receipt and resolution of an Expedited Clinical Grievance.
9. The Supervisor, Regulatory Affairs, or designee, provides a written statement to the DMHC about the disposition or pending status of the Expedited Clinical Grievance within three calendar days of receipt of the Grievance. This is documented in SFHP's Care Management System.

III. State External Review of Clinical Grievances

1. SFHP has one internal level of Grievance resolution. Members may contact SFHP Customer Service to have a previously issued resolution for a Clinical Grievance reconsidered; however, members are not required to participate in SFHP's Grievance process for more than 30 calendar days and are encouraged to seek external review.
2. If the member does not agree with the decision made by SFHP or its delegate on the Clinical Grievance, members may seek no-cost external review of their Clinical Grievance by contacting the DMHC. The member's complaint is eligible

for Independent Medical Review (IMR) if the complaint was based on a decision in whole or in part on a determination that the service is not medically necessary, the requested service is experimental/investigational, or the case involves an emergency service. Otherwise, DMHC reviews the complaint as a Consumer Complaint.

3. The Supervisor, Regulatory Affairs, or designee, is responsible for coordinating responses to DMHC about IMRs and Consumer Complaints per CRA-24.
4. Medi-Cal members may contact the State Ombudsman's Office toll-free at 1-888-452-8609 for assistance with a Clinical Grievance involving Medi-Cal services.
5. Members are required to exhaust SFHP's Grievance Resolution process prior to seeking external review, except when the DMHC determines that extraordinary and compelling circumstances exist, including when there is an imminent and serious threat to the health of the member.

IV. Clinical Decline-to-File Grievances

If a member, or his/her/their representative, expresses dissatisfaction with SFHP or one of its providers, but specifically declines to file a Grievance or Appeal, SFHP performs the following procedure:

1. Pursuant to CS-13, the Customer Service Representative documents the details of the Decline-to-File Grievance on the Grievance Intake Form and enters the Decline-to-File Grievance in SFHP's Care Management System.
2. HOI QR RN reviews the member's statement for any clinical and/or PQI components.
3. If HOI QR RN determines the complaint is clinical, HOI/ACE Grievance Coordinator sends a Decline-to-File Grievance Acknowledgement Letter to the member within five (5) calendar days of receipt.
4. The Decline-to-File Grievance is reviewed for PQI according to QI-18.

V. Exempt Grievances

1. 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.
2. Per CS- 13, a Grievance that is resolved to the member's satisfaction during the duration of a phone call is categorized as an Exempt Grievance in the grievance log in QNXT.
3. If the Grievance is not resolved during the duration of a call, the Grievance is entered in SFHP's Care Management System.

4. If the Grievance is resolved by the close of the next business day, the Grievance is categorized as an Exempt Grievance in SFHP's Care Management System.
5. If the Grievance is not resolved by the close of the next business day, it is processed as a non-exempt Grievance pursuant to applicable processing timelines.

VI. Oversight Committee Roles and Responsibilities

1. Quality Improvement Committee Oversight

a. The Chief Medical Officer (CMO) has primary responsibility for SFHP's Clinical Grievance system.
b. The SFHP Quality Improvement Committee (QIC) oversees the Grievance process.
c. The SFHP Director of HOI is responsible for maintaining Grievance procedures, reviewing the operation of the process, and leading SFHP's quality committee to identify emergent patterns of Grievances in order to initiate systemic improvements in SFHP operations.
d. At least quarterly, the Governing Board reviews the activities of all quality committees. The Governing Board may direct SFHP to improve the quality and efficiency of the Grievance process, or to initiate improvement activities that directly address the individual or systemic issues raised.
e. A summary of the written record of Clinical Grievances is submitted at least quarterly to QIC. Aggregated reports show Clinical Grievances related to access to care, quality of care, attitude and service, quality of practitioner office site. Analysis supports quality improvement efforts.

2. Grievance Program Leadership Team (PLT)

a. Grievance PLT includes the following leaders: CMO, Director of Member Services, Manager of Customer Service, Director of HOI, Manager of ACE, and Chief Compliance Officer.
b. PLT meets quarterly. Ad hoc meetings may be called by any member of the committee, as needed, to discuss issues.
c. PLT reviews Clinical Grievance operational data such as, but not limited to, Clinical Grievance volume, processing turnaround time, and trends by category.
d. PLT reviews a report of Clinical Grievance data related to cultural and linguistic services and Grievances where a member has experienced discrimination.
e. Each issue brought to PLT includes a summary of the issue, appropriate facts and action(s) taken to date to resolve the issue.
f. PLT members discuss the issue(s), recommend action(s) to resolve, and assign responsibility for actions to committee member(s).
g. PLT member(s) with assigned task(s) update the Grievance staff member of outcomes prior to the following meeting or sooner depending on the urgency of the issue(s).

h. PLT reviews aggregate data for trends and makes recommendations for interventions when opportunities for improvement identified also include review of delegate Grievance reports.
i. PLT provides oversight of Grievance functions including, but not limited to, audits, reporting, regulatory requirements, review of system level trends or trends identified at GRC and initiates corrective action, if necessary.
j. PLT discusses internal and external updates that could affect the volume or type of Grievances received.

3. Grievance Review Committee (GRC) (Internal)

a. SFHP's GRC reviews Grievances and proposed resolution letters to ensure all components of the Grievance are investigated and resolved in compliance with regulations.
b. A SFHP Medical Director or clinician designee leads the committee and determines the final resolution of each Grievance.
c. The SFHP Medical Director or clinician designee reviews the written record of every Grievance.
d. Committee membership includes representatives from Customer Service, Provider Network Operations, Health Outcomes Improvement, and Compliance and Regulatory Affairs.
e. Designees from Pharmacy, Utilization Management, and Claims departments attend as needed.
f. The HOI Grievance Analyst, or designee, presents any trends or egregious Grievances to the committee to determine actions needed to address the issue(s).
g. Committee recommends improvement opportunities, provider follow up or corrective action. Medical groups and providers must take corrective action as identified by the GRC, and also address systemic issues identified in the Grievance process. The Grievance PLT provides oversight and follow-through of GRC recommendations.

VII. Special Considerations

If a Grievance involves one of the following issues, the Grievance is subject to additional review and/or classification as described below:

1. Delegated Grievance Processes

a. SFHP delegates the responsibility for processing Grievances and Appeals to certain Knox-Keene licensed health care service plans. SFHP fully delegates the Grievance process to one (1) health plan, Kaiser Health Plan Foundation.
b. SFHP partially delegates the responsibility for processing Grievances to Beacon Health Options ("Beacon"). Under partial delegation, SFHP requires Beacon to present all Grievances to SFHP's Grievance Review Committee ("GRC"). GRC reviews the Grievance and proposed resolution letter to ensure that all components of the Grievance are resolved.

c. Per CS-13, if SFHP receives a Grievance, the processing of which is delegated, the Customer Service Representative still performs intake of the Grievance or Appeal. The Medical Director and/ or HOI QR RN determines whether the Grievance should be processed by SFHP or forwarded to the delegated entity for processing. For more information, see the Desktop Procedures for Delegated Grievances.

2. Carved Out Services

a. SFHP does not provide or pay for services that are the responsibility of another entity or program ("Carved Out Services" or "Other Health Coverage").
b. Grievances involving the following entities or programs are reviewed by the HOI QR RN and/or Medical Director to determine if investigation is indicated:
    i. California Children's Services (CCS), Medicare, San Francisco Behavioral Health Services (BHS) and Denti-Cal.
c. Grievances and Appeals involving Carved Out Services and Other Health Coverages not listed above are reviewed by the HOI QR RN and/or Medical Director on a case-by-case basis to determine appropriate handling of the Grievance.
d. If investigation is not necessary, the Customer Service or HOI/ACE Grievance Coordinator closes the Grievance in SFHP's Care Management System and sends a Grievance Resolution Letter providing the member with instructions on how to contact and file a Grievance with the entity/program responsible for providing the Carved Out Service or Other Health Coverage.
e. For more information, see the Desktop Procedures for Grievances and Appeals involving Carved Out Services and Other Health Coverage.

3. Cultural and Linguistic Requirements

a. The HOI Grievance Coordinators are trained by the Program Manager, Population Health on cultural and linguistic requirements. This procedure ensures the HOI Grievance Coordinators are able to identify any cultural and linguistic issues raised in Grievances.
b. The Program Manager, Population Health performs a review of all Grievances involving cultural and/or linguistic concerns including alleged discrimination by SFHP providers or staff to ensure accurate identification and resolution of issues. For more information, see HECLS Desktop Procedure (DTP).
c. SFHP forwards Grievances alleging discrimination against Medi-Cal members because of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability to DHCS for review and appropriate action. The HOI Grievance Coordinator sends the member's CIN number, copies of the case notes, provider response (if any), and resolution letter to the Supervisor, Regulatory Affairs, or designee, for forwarding to DHCS. This is documented in SFHP's Care Management System.

4. **Identification, Documentation and Tracking/Trending Disability Components of Member Grievances**
   The HOI QR RN, or designee, reviews all Grievances for disability components, for example, wheelchair access.

MONITORING

1. HOI Grievance Analyst compiles a quarterly grievance report for all Medical Groups. Provider Network Operations designee submits a quarterly grievance report to all Medical Groups.
2. HOI Grievance Analyst compiles and submits a quarterly Grievance report to SFHP's QIC.
3. HOI Grievance Analyst and Delegation Oversight designee reviews the Grievance log and/or conducts annual audits of entities delegated for the processing of Grievances.
4. SFHP submits a quarterly report of Decline-to-File Grievances and Exempt Grievances to the Grievance PLT.
5. SFHP completes an annual Grievance and Appeals report according to NCQA requirements and submits to PLT for review.
6. Clinical Decline-to-File Grievances are reviewed monthly by the HOI QR RN and Medical Director to determine if there are any PQIs present according to QI-18. Decline-to-File Grievances are also included for review of grievance trends.
7. Reference CS-13 for Exempt Grievance monitoring and trending.
8. The Supervisor, Compliance Program, or designee, performs an internal audit of Grievances and Appeals on a quarterly basis.
9. SFHP monitors entities delegated for the processing of Grievances and Appeals pursuant to DO-08 Oversight of Delegated Grievances.
10. Pursuant to CLS-02, the Program Manager, Population Health, performs annual oversight audits of Grievances to ensure that cultural and linguistic issues are being identified, logged and appropriately addressed.

Internal Monitoring:

1. HOI Grievance Analyst reviews and analyzes all grievances on a monthly basis.
2. A Grievance trend is three or more grievances during a rolling three-month period (filed by unique members) that involve the same provider or clinic and grievance category. Actions on Grievance trends are decided by GRC and/or PLT. HOI Grievance Analyst reviews and analyzes all Clinical Grievances on a monthly basis to identify trends.
3. A quarterly Inter-Rater-Reliability process ensures appropriate initial classification of Clinical Grievances and expedited/standard timeframes. The ACE Specialist or designee selects and blinds 10 cases. SFHP's Medical Director reviews the cases and assigns "clinical or non-clinical" and "expedited/non-expedited" classifications to each case. If the results are less than 90% reliable between the Medical Director and HOI QR RN, the HOI QR RN receives additional training and supervision.

DEFINITIONS

Administrative Appeals: an appeal of a denial not based in whole or in part of a determination of medical necessity by SFHP including benefit coverage determinations. Administrative Appeals are subject to the requirements in NCQA RR 2. SFHP classifies this type of appeal as a Grievance. Please see policies and procedures QI-06 Clinical Member Grievances and CS-14 Non-Clinical Member Grievances.

Clear and Concise Language: sentences are less than 20 words in length. Words of more than 2 syllables are avoided. Flecsh-Kincaid score of 80% readability.

Clinical Grievance: any issue concerning the services provided by a clinic, hospital, provider or pharmacy. Clinical Grievance types include but are not limited to:

a. Quality of service (by clinic/hospital/provider)
b. Access
c. Pharmacy issues
d. Quality of medical Care
e. Denials and/or refusals (formulary, denial of service/treatment)
f. Cultural, linguistic, and health education (by clinic/hospital/provider)

Consumer Complaint: a complaint filed by a member with DMHC about SFHP or its providers that does not meet the criteria for IMR.

Decline-to-File Grievance: an expression of dissatisfaction where, upon intake, the member or member's representative expressly declines to file a formal Grievance or Appeal. Decline-to-File grievances are aggregated for tracking and trending purposes

Disputed Health Care Service: any health care service that is eligible for coverage and payment by SFHP or medical group that has been delayed, denied, or modified by a decision of SFHP 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.

Dual-Eligible Member: a member that qualifies for both Medicare and Medi-Cal coverage.

Exempt Grievance: a grievance received over the telephone that is not a coverage dispute, disputed health care service involving medical necessity or experimental or investigational treatment, and is resolved by the close of the next business day. These grievances are exempt from the requirement to send a written acknowledgment and resolution.

Expedited Review: an accelerated review and reporting process for grievances involving an imminent and serious threat to the member's health. 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.

Grievance: a written or oral expression of dissatisfaction regarding the plan and/or provider about any matter other than an Adverse Benefit Determination, including quality of care concerns, and may include a complaint or dispute made by an enrollee or the enrollee's representative to SFHP or to any entity with delegated authority to resolve grievances on behalf of SFHP. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. This also includes administrative appeals.

Independent Medical Review (IMR): the expert review of disputed health care services by an outside organization that contracts with the Department of Managed Health Care (DMHC).

Non-Clinical Grievance: a Non-Clinical Grievance is defined as an expression of dissatisfaction by a member about any issue concerning the services provided by SFHP and its non-clinical components. The types of complaints considered to be Non-clinical Grievances types:

a. Billing
b. Benefits/Coverage (benefits, does not like HMO business rules)
c. Cultural, Linguistic, and Health Education (by SFHP staff, SFHP materials)
d. Quality of Service (by SFHP staff)
e. Enrollment (cancellation of coverage, premium increase)
f. Report of potential inaccuracy in the printed or online provider directory(ies)

Notice of Action (NOA) or Notice of Adverse Benefit Determination (NABD): a formal letter telling members that a medical service has been denied, deferred, or modified.

Potential Quality Issue (PQI): an identified adverse variation from expected clinical standard of care requiring further investigation. A PQI can lead to a confirmed provider or system quality issue or opportunity for improvement.

Resolved: the grievance has reached a final conclusion with respect to the member's submitted grievance, and there are no pending member appeals within the plan's grievance system, including entities with delegated authority.

AFFECTED DEPARTMENTS/PARTIES

Claims
Clinical Operations
Compliance & Regulatory Affairs
Customer Service

Health Outcomes Improvement
Marketing and Communications
Pharmacy
Provider Network Operations

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. Member Appeals Policy (QI-17)
2. Member Grievances and Appeals: Rights, Intake and Case Creation (CS-13)
3. Non-Clinical Member Grievances and Non-Clinical Decline-to-File Grievances (CS-14)
4. Oversight of Delegated Grievances (DO-08)
5. Use of Interpreter Services and Bilingual Staff (CLS-02)
6. Potential Quality Issues (QI-18)
7. Responding to State Inquiries about Member Complaints (CRA-24)
8. Decline-to-File Acknowledgment Letter
9. Grievance Acknowledgment Letter
10. Downgrade Acknowledgment Letter
11. Grievance Resolution Letter
12. Grievance Intake Form
13. DTP Delegated Grievances
14. DTP HECLS
15. DTP Beacon Grievances
16. DTP Carve Out Services
17. DTP Grievance Review Committee

REVISION HISTORY

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Revised July 22, 2008 for DHCS contract deliverable requirement
Revised June 15, 2009 to include MMCD Policy Letter 09-006, 2009 DMHC/DHCS Joint Audit CAP Req. 4.1.1 & 6.1.1, and internal processes to include trending grievances for members with disabilities.
Revised December 24, 2009 for internal process changes related to the DMHC/DHCS Joint Audit CAP Req. 4.1.1 & 6.1.1
Revised March 23, 2010 for internal review
Revised April 15, 2011 to include services to SPD members
Revised February 22, 2012,to include schedule for reporting to

DHCS and DMHC
April 2012
July 29, 2013
January 22, 2014: revised to include NCQA standards
April 1, 2014
Revised September 8, 2014 to include DHCS Audit 2014 Recommendations
Revised November 21, 2014 to include process for non-expedited grievances.
Revised March 20, 2015 to update appeal process for NCQA 2015 standards.
Revised April 29, 2015 update that the committee will review the most severe PQI cases following UM-56.
Revised July 8, 2015 update grievance and appeal process for NCQA 2015
Revised September 8, 2015 update internal committee responsibilities
Revised November 4, 2015 update grievance process, include separate section for exempt grievances
Revised January 12, 2016
Revised April 13, 2016 NCQA
Revised May 6, 2016 Reports of provider directory inaccuracies
Revised June 27, 2016 Clarified Expedited process; Administrative appeals for NCQA
Revised September 16, 2016 DHCS 2015 CAP Responses
Revised November 11, 2016 NCQA 2017 Standard UM
Revised December 20, 2016 NCQA 2017 Standard UM
Revised April 1, 2017 NCQA 2017 Standards UM and RR
Revised May 19, 2017 APL 17-006
Revised June 13, 2017 DHCS AIR APL 17-006
Revised October 11, 2017 Expedited review & Carved Out Services
Revised January 4, 2018 28 CCR 1300.68.01 (a), NCQA Annual Reports
Revised March 16, 2018, May 2018, June 10, 2019

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, 1367.27, 1368, 1368.01, 1368.02, 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

7. Code of Federal Regulations, Title 42, Section 438.406 (b)3
8. MMCD Policy Letter 09-006: Timeframes for Member Grievances
9. APL 17-006 Grievance and Appeal Requirements
10. NCQA Standards QI-4 Member Experience and NET-3 Assessment of Network Adequacy

APPENDIX A

Medi-Cal

Letter Type	Attachments
Grievance Acknowledgment	Language Assistance Taglines and Nondiscrimination Notice
Grievance Acknowledgement and Downgrade of Expedited to Standard Grievance	Language Assistance Taglines and Nondiscrimination Notice
Grievance Resolution	Language Assistance Taglines and Nondiscrimination Notice
Grievance/Appeal Withdrawal	Language Assistance Taglines and Nondiscrimination Notice
Decline to File	Language Assistance Taglines and Nondiscrimination Notice

Healthy Workers HMO and Healthy Kids HMO

Letter Type	Attachments
Grievance Acknowledgment	Language Assistance Taglines and Nondiscrimination Notice
Grievance Acknowledgement and Downgrade of Expedited to Standard Grievance	Language Assistance Taglines and Nondiscrimination Notice
Grievance Resolution	Language Assistance Taglines and Nondiscrimination Notice
Grievance/Appeal Withdrawal	Language Assistance Taglines and Nondiscrimination Notice
Decline to File	Language Assistance Taglines and Nondiscrimination Notice

Appendix B

Grievance Type	Acknowledgement	Resolution
Expedited		Oral notice within 72 hours
Downgraded from Expedited to Standard	Oral notice within 5 days Written notice within 5 days	Written notice within 30 days of receipt
Standard	Written notice within 5 days	
Decline-to-File	Written notice within 5 days	
Redirected to Delegate	Written notice of redirection within 5 days	