SFHP POLICY AND PROCEDURE

Member Grievances and Appeals: Rights, Intake and Case Creation

Policy and Procedure Number:	CS-13
Department Owner:	Customer Service
Lines of Business Affected:	Medi-Cal, Healthy Workers HMO, Healthy Kids HMO

POLICY STATEMENT

San Francisco Health Plan (SFHP) encourages its members, or member's representative(s), to inform SFHP about SFHP's or its providers' operations, services, quality of care, decisions or other aspect about their health care. SFHP intakes these expressions of dissatisfaction and processes them as Grievances, Appeals, Exempt Grievances or Decline-to-File Grievances. SFHP informs members of their right to submit Grievances and/or Appeals to SFHP. SFHP informs providers about the SFHP Grievance and Appeal process.

PROCEDURE

I. Scope

The policy and procedure describes: members' rights regarding the Grievance and Appeal process; SFHP's methods of informing SFHP members and providers about SFHP's Grievance and Appeal process; the process by which SFHP Customer Service intakes Grievances and Appeals; and the procedure for Exempt Grievances. Non-Clinical Grievance and Non-Clinical Decline-to-File Grievance procedures are discussed in CS-14. Clinical Grievance and Clinical Decline-to-File Grievance procedures are in QI-06. Adverse Benefit Determinations and decisions by SFHP to deny, delay or modify health care services are processed as Appeals in accordance with QI-17.

II. General

a. Members' Rights

1. SFHP members, a provider acting on behalf of the member, or an authorized representative may file a Grievance or Appeal for any reason, either orally or in writing.
2. Medi-Cal members can file a Grievance at any time. Medi-Cal members may request review of Adverse Benefit Determinations made by SFHP or its delegated medical groups by filing an Appeal with SFHP. If a Medi-Cal member disagrees with an Adverse Benefit Determination, the member has sixty (60) calendar days from the date of the Notice of Action (NOA) to file an Appeal.

3. Healthy Workers HMO and Healthy Kids HMO members may submit a Grievance or Appeal within one-hundred and eight (180) calendar days following any incident or action that is the subject of the member's dissatisfaction. For Appeals, Healthy Workers HMO and Healthy Kids HMO members may request review of a delay, modification or denial of services based on medical necessity, or a determination that the requested service was not a covered benefit, within one-hundred and eighty (180) calendar days from the date of the decision to deny, modify or delay a health care service.
4. SFHP complies with California law that requires all internal levels of Grievance and Appeal resolution be completed within 30 calendar days of the plan's receipt of the Grievance or Appeal. SFHP has one internal level of Grievance and Appeal resolution.
5. SFHP notifies members of the disposition of a standard Grievance or standard Appeal within 30 calendar days and within 72 hours for an Expedited Grievance or Expedited Appeal.Members are not required to participate in SFHP's Grievance and Appeal process for more than 30 calendar days of SFHP's receipt of the member's Grievance or Appeal. In the case of an Expedited Grievance or Expedited Appeal, the member is not required to participate in SFHP's Grievance and Appeal process prior to requesting external review.
6. SFHP does not dis-enroll, discriminate, or retaliate against a member because he/she/they filed a Grievance or Appeal.
7. A member has a right to continuous medical care. A SFHP provider cannot withhold or terminate care because a member has filed a Grievance or Appeal.
8. A member has the right to have a representative, advocate and/or lawyer assist in the Grievance and Appeal process.
9. A member has the right to interpreter services during any part of the Grievance and Appeal process. Standard documents and correspondence are available in SFHP's threshold languages. 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.
10. A member has the right to propose a solution to a Grievance or Appeal.
11. When a member requests Expedited Review, the member has the right to be informed, by SFHP, of the limited time available to present evidence in support of a Grievance or Appeal.
12. If requested by the member, SFHP must provide documentation records in connection with a Grievance or Appeal.
13. The member and/or his/her/their representative may request copies of the information SFHP used to make the Grievance or Appeal resolution decision, including any criteria or guidelines used, free of charge.
14. Members may seek external review of their Grievance or Appeal. Except for Expedited Grievances and Expedited Appeals, the member is required to participate in SFHP's Grievance and Appeal process prior to seeking external review by the Department of Managed Health Care (DMHC), unless DMHC determines that extraordinary and compelling circumstances exist. Medi-Cal members may seek assistance with their Grievance or Appeal from the State Ombudsman's Office or request a State Fair Hearing with the Department of Health Care Services (DHCS).

Medi-Cal members are required to exhaust SFHP's internal Appeal process and receive notice that an Adverse Benefit Determination has been upheld prior to proceeding to a State Fair Hearing.

b. Informing Members of the Grievance and Appeal Process

SFHP assists its members in understanding and using all internal and external Grievance and Appeal processes available to them. SFHP provides members access to comprehensive, accurate and easily understood information about the Grievance and Appeal process. A description of the Grievance and Appeal process is published in the Member Guidebook, Member Handbook/Evidence of Coverage and Disclosure Form (EOC), Notice of Action letters, Grievance Forms and SFHP website. At minimum, the following information is included:

1. How to file a grievance, by phone, fax, online at sfhp.org, online via SFHP's member portal, or in person, verbally or in writing, by contacting the primary care practitioner's office, the medical group or SFHP;
2. How to appeal an Adverse Benefit Determination or decisions by SFHP to deny, delay or modify health care services;
3. How to contact the SFHP Customer Service Department for assistance in the Grievance or Appeal process, to find an independent advocate, to access interpreter services or for any other reason;
4. How to request an Expedited Grievance or Expedited Appeal;
5. How to contact the DMHC, using DMHC's toll-free telephone number, DMHC's telephone number for relay services provided for the hearing and speech-impaired, and DMHC's website;
6. *For Medi-Cal beneficiaries:* how to request continuation of benefits pending the resolution of an Appeal, how to request a State Fair Hearing and how to reach the DHCS Ombudsman, using toll-free and TDD phone numbers;
7. SFHP's nondiscrimination notice; and
8. Taglines in the top fifteen languages used in California informing the member how to obtain free interpreter services.

c. Informing Providers of the Grievance and Appeal Process

SFHP informs its providers about the Grievance process through the Provider Manual, Summary of Key Information, and through regular trainings and audits.

Medical groups and providers are expected to inform members of their right to file a Grievance against SFHP or its delegated medical groups and to assist members in the SFHP Grievance process. SFHP distributes Grievance Forms in the required threshold languages to all primary care and medical group offices. SFHP also has the Grievance Form available on SFHP.org. Providers and medical group staff must have the Grievance Form readily available for members wishing to file a Grievance.

III. Intake

SFHP ensures that members have the opportunity to provide a detailed description of the dissatisfaction for which they are seeking a Grievance or Appeal. Except where the processing of Grievances and Appeals is delegated to another entity, the Customer Service Department performs intake of all Grievances and Appeals.

1. Members, or their representatives, may file a Grievance or Appeal with SFHP by phone, mail, fax, online, in person at SFHP's Service Center, or through SFHP's website. Members may submit their Grievance or Appeal in writing by filling out a Grievance Form.
2. Former members who are not enrolled in a SFHP line of business may submit a Grievance or Appeal if the event(s) on which the Grievance or Appeal is based occurred while the former member was an eligible member in a SFHP line of business or if the decision stated in the Notice of Action was made by SFHP or one of its contracted providers or delegated medical groups.
3. SFHP Health Services staff, providers and staff of SFHP-contracted providers may refer the member to the SFHP Customer Service Department and/or directly assist the member to file a Grievance by phone.
4. Requests for a State Fair Hearing from the DHCS, Independent Medical Review requests from the DMHC, or Consumer Complaints from the DMHC may be identified as new Grievances or Appeals if the member has not previously raised the issue with SFHP. Grievances may also be identified as the result of an inquiry or other communication with the DHCS or DMHC.
5. Customer Service Representatives document the details of the expression of dissatisfaction on the Grievance Intake Form.
6. If a member requests an Expedited Grievance or Expedited Appeal, the Customer Service Representative immediately notifies the member of their right to contact the DMHC about the Grievance or Appeal as follows:
    a. Telephone calls to Customer Service – If the member calls Customer Service and requests their Appeal to be expedited, the Customer Service Representative immediately informs the member about their right to contact DMHC about the Grievance or Appeal and provides the member with DMHC's phone number. The Customer Service Representative documents in the Grievance Intake Form.
    b. Online Grievance Form – Members submitting Grievances or Appeals via the online Grievance Form are immediately informed about how to contact the DMHC about their Grievance or Appeal because that information appears on the online Grievance Form itself. The Customer Service Representative documents this in the Grievance Intake Form.
    c. Written Grievance Form – Members submitting Grievances or Appeals in writing using the Grievance Form are immediately informed about how to contact the DMHC about their Grievance or Appeal because that information appears on the Grievance Form. Members may submit the Grievance Form to SFHP by mail, fax or in-person. The Customer Service Representative documents this in the Grievance Intake Form.

d. Members who request Expedited Review of a Grievance or Appeal via a method other than a telephone call to Customer Service, online Grievance Form or written Grievance Form are contacted by a Customer Service Representative upon receipt of the Grievance or Appeal and informed about the right to contact DMHC about their Grievance or Appeal.

7. SFHP delegates the responsibility for processing Grievances and Appeals to certain Knox-Keene licensed health care service plans. If SFHP receives a Grievance or Appeal, the processing of which is delegated, the Customer Service Representative still performs intake of the Grievance or Appeal. The Medical Director determines whether the Grievance or Appeal should be processed by SFHP or forwarded to the delegated entity for processing. For more information, see the Desktop Procedures for Delegated Grievances.
8. SFHP does not provide or pay for services that are the responsibility of another entity or program ("Carved Out Services" or "Other Health Coverage"). Grievances and Appeals involving the following entities or programs will be reviewed by the HOI Quality Review RN and/or Medical Director to determine if investigation is indicated: California Children's Services (CCS), Medicare, San Francisco Behavioral Health Services (BHS) and Denti-Cal.
9. The Customer Service Representatives are trained to gather details around discrimination.
10. Upon intake, members, or their representatives, are informed that they may review all documents, including medical records, associated with the Grievance or Appeal case, at any time during the Grievance or Appeal review process. Members are also informed that they have the right to submit additional evidence in support of their grievance.

IV. Case Creation

SFHP's Care Management System tracks the following types of member Complaints:

i. Decline-to-File Grievances
ii. Exempt Grievances
iii. Non-Clinical Grievances
iv. Clinical Grievances
v. Pre-Service Appeals (Clinical)
vi. Post-Service Appeals (Non-Clinical or Clinical)

The CS or HOI/ACE Grievance Coordinator ensures a unique identifier is assigned to every Grievance. All Grievances include a case assessment where structured data are collected, available for analysis and reporting. All calls and contact with the member, their representative and any other persons involved with investigation are documented in SFHP's Care Management System.

Once entered into SFHP's Care Management System, the Customer Service Coordinator routes the Grievance to the Health Outcomes Improvement (HOI) Quality Review RN for triage.

V. Exempt Grievances

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 entered into QNXT as an "exempt" grievance. The Customer Service Grievance Coordinator determines which Grievances are "exempt" using the Exempt Grievance Checklist.

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. If the Grievance is not resolved during the duration of a call, the Grievance is entered in SFHP's Care Management System. 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. 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.

SFHP maintains logs of all Exempt Grievances recorded in both QNXT and SFHP's Care Management System that contains the date of the call, the name of the Complainant, member identification number, nature of the Grievance, nature of the resolution, and the name of the representative who took the call and resolved the Grievance.

VI. Grievance and Appeal Notices

Notices sent to members regarding the receipt and disposition of their Grievance or Appeal include Acknowledgement Letters, Downgrade Acknowledgement Letters, Notices of Appeal Resolution, Grievance Resolution Letters, Decline-to-File Letters, and documents describing Appeal and external review rights ("Your Rights" notices). These notices are based on templates reviewed and approved by DHCS and DMHC. The notice templates are translated into Medi-Cal, Healthy Kids HMO and Healthy Workers HMO threshold lanauges. Each notice includes SFHP's nondiscrimination notice in English or the member's preferred threshold language and taglines in the top fifteen languages used in California informing the member how to obtain free interpreter services.

MONITORING

1. The Director, Claims, Customer Service, and Member Eligibility and the Manager, Customer Service, or their designees, perform monitoring of phone calls answered by Customer Service Representatives pursuant to CS-03 Monitoring of Telephone Calls. Monitoring includes whether expressions of dissatisfaction were properly identified as Grievances or Appeals and whether interpreter services were offered, as appropriate.

2. To ensure the appropriate initial classification of Grievances between Clinical and Non-Clinical Grievances and expedited and non-expedited, internal monitoring by inter-rater reliability is conducted on a quarterly basis. Each quarter, a random selection of 10 cases is selected for review. The 10 cases are blinded and the SFHP Medical Director reviews the cases and assigns "clinical or non-clinical" classifications to each case. SFHP has a 90% inter-rater reliability threshold. If the results are less than 90%, the SFHP Medical Director provides additional training and supervision to the HOI Quality Review RN.
3. Per QI-06, a HOI/ACE Grievance Analyst reviews and analyzes all Clinical Grievances on a monthly basis to identify trends. Clinical Decline-to-File Grievances are included in the analysis. The analysis is presented to the Grievance Program Leadership Team on a quarterly basis.
4. Per CS-14, Director, Customer Service, Claims and Member Eligibility, reviews and analyzes all Non-Clinical Grievances on a quarterly basis to identify trends. All Exempt Grievances are included in the analysis. The analysis is presented to the Grievance Program Leadership Team on a quarterly basis.
5. The Supervisor, Compliance Program, or designee performs an audit of Grievances and Appeals on a quarterly basis.
6. SFHP submits a quarterly grievance report to the Delegated Medical Groups.
7. SFHP monitors entities delegated to process Grievances and Appeals pursuant to DO-08 Oversight of Delegated Grievances.

DEFINITIONS

Administrative Appeals: an appeal of a decision that is not about coverage or medical necessity. SFHP classifies and processes Administrative Appeals as Clinical or Non-Clinical Grievances. Please see policy QI-06 Clinical Member Grievances and CS-14 Non-Clinical Member Grievances and Non-Clinical Decline-to-File Grievances.

Adverse Benefit Determination: any of the following actions taken by SFHP:

- Denial or limited authorization of a requested service, including determinations based on the type or level of service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to provide services in a timely manner.
- Failure to act within required timeframes for resolution of Grievances and Appeals.
- Denial of a beneficiary's request to dispute financial liability.

Appeal: a request by a member for review of an Adverse Benefit Determination, including, delay, modification or denial of services based on medical necessity or a determination that the requested service was not a covered benefit.

Carved Out Services: health care services, prescription drugs, waiver programs and other services that are not covered under the Medi-Cal managed care program or specifically excluded from SFHP's Medi-Cal contract with DHCS.

Clinical Grievance: an expression of dissatisfaction about any issue concerning the services provided by a clinic, hospital, provider or pharmacy. The types of grievances considered to be clinical in nature include:

- Quality of Service (by clinic/hospital/provider)
- Access
- Pharmacy issues
- Quality of Medical Care
- Denials, Refusals (formulary, denial of service/treatment)
- Cultural, Linguistic, and Health Education (by clinic/hospital/provider)

Complainant: the same as "grievant"; the individual that filed the grievance, including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.

Decline-to-File Grievance: a expression of dissatisfaction where, upon intake, the member or member's representative, expressly declines to file a formal Grievance or Appeal.

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.

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 Appeal: see "Expedited Review".

Expedited Grievance: see "Expedited Review".

Expedited Review: an accelerated review and reporting process for Grievances and Appeals 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. Grievances and Appeals that are determined to require Expedited Review are considered "Expedited Appeals" and "Expedited Grievances".

Grievance: a written or oral expression of dissatisfaction regarding the plan and/or provider about any matter other than an Adverse Benefit Determination or decisions by SFHP to deny, delay or modify health care services, 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. Grievances may include quality of care and quality of service issues. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. A Grievances are also known as an Administrative Appeal.

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: an expression of dissatisfaction about any issue concerning the services provided by SFHP and its non-clinical components. The types of complaints considered to be non-clinical in nature include:

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

Notice of Action (NOA): a formal letter informing members that a health care service has been denied, deferred, or modified.

State Fair Hearing: a review by a California Department of Social Services administrative law judge of a Medi-Cal member's Grievance about how Medi-Cal benefits or services were handled or a denial or modification of Medi-Cal benefits or services.

AFFECTED DEPARTMENTS/PARTIES

Care Management
Claims
Clinical Operations
Compliance & Regulatory Affairs
Customer Service
Delegated Groups
Health Outcomes Improvement
Network Provider
Pharmacy Services
Provider Network Operations

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. “Your Rights” Notice
2. CLS-02 Use of Interpreter Services and Bilingual Staff
3. CRA-24 Responding to Regulators’ Requests About Member Complaints
4. CS-03 Monitoring of Telephone Calls
5. CS-14 Member Grievances: Non-ClinicalNon-Clinical Member Grievances and Non-Clinical Decline-to-File Grievances
6. Decline-to-File Grievance Acknowledgement Letter Template
7. DO-02 Oversight of Delegated Functions
8. DO-08 Oversight of Delegated Grievances
9. Downgrade Acknowledgment Letter Template
10. DTP Beacon Grievances
11. DTP Carved Out Services
12. DTP Delegated Grievances
13. DTP Grievance Review Committee
14. Exempt Grievance Checklist
15. Grievance Acknowledgment Letter Template
16. Grievance Form
17. Grievance Intake Form
18. Grievance Resolution Letter Template
19. MC-03 Translation of Member Material
20. Member Guidebook
21. Member Handbook and/or Evidence of Coverage and Disclosure Form
22. Notice of Appeal Resolution Letter Template
23. PR-21: Data Maintenance For Providers Participating in SFHP
24. Provider Manual
25. QI-06 Clinical Member Grievances
26. QI-17 Member Appeals
27. QI-18 Potential Quality Issues
28. San Francisco Health Plan Grievance Categories
29. Summary of Key Information

REVISION HISTORY

Effective Date: July 2, 2019
Approval Date: June 20, 2019
Revision Date(s):

REFERENCES

1. Code of Federal Regulations, Title 42, Section 438.406 (b)3
2. DHCS All Plan Letter 17-006 Grievance and Appeal Requirements

3. 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
4. NCQA Standards RR 2 Policies and Procedures for Complaints and Appeals
5. Title 22, California Code of Regulations, Section 53858, 53893, 51014
6. Title 28, California Code of Regulations, Section 1300.68
7. Welfare and Institutions Code 10961