SFHP POLICY AND PROCEDURE

Non-Clinical Member Grievances and Non-Clinical Decline-to-File Grievances

Policy and Procedure Number:	CS-14
Department Owner:	Customer Service
Lines of Business Affected:	Medi-Cal, Healthy Workers HMO, Healthy Kids HMO

POLICY STATEMENT

Non-Clinical Grievances and Non-Clinical Decline-to-File Grievances are expressions of dissatisfaction by members about any issue concerning the services provided by SFHP and its non-clinical components. San Francisco Health Plan's (SFHP) Customer Service Department addresses and resolves members' Non-Clinical Grievances and Non-Clinical Decline-to-File Grievances in a manner that is timely, fair and thorough. SFHP's Non-Clinical Grievance and Non-Clinical Decline-to-File Grievances processes comply 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

SFHP defines a Grievance as any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (Notice of Action) or decision by SFHP to deny, delay or modify a heatlh care service. Grievances are also known as Administrative Appeals. This policy and procedure describes the specific processes by which the Customer Service Department investigates and processes Non-Clinical Grievances and Non-Clinical Decline-to-File Grievances.

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 in nature include:

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)
g. Complaints alleging discrimination by SFHP staff

Grievances and Appeals member rights, intake, case creation, and Exempt Grievances are discussed in CS-13. Clinical Grievance and Clinical Decline-to-File Grievance procedures are discussed 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. Standards for Processing Non-Clinical Grievances and Non-Clinical Decline-to-File Grievances

a. Filing Timeframes

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

b. Intake

SFHP Customer Service performs intake of complaints, including Non-Clinical Appeals, and entry of Complaints in SFHP's Care Management System, pursuant to CS-13. Per CS-13, Members requesting Expedited Review of complaints are informed of their right to contact the Department of Managed Health Care (DMHC) about their complaint.

c. Triage

The Health Outcomes Improvement (HOI) Quality Review RN reviews each Complaint within one (1) business day of receipt to determine whether a complaint is a Grievance or an Appeal, whether it involves clinical or non-clinical issues (complaints involving both clinical and non-clinical issues will be classified as clinical), whether it requires Expedited Review (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 majory bodily function), whether it involves services already rendered, whether it presents any Potential Quality Issues (PQI), whether it is related to any Carved Out Services, and whether it is related to Other Health Coverage (e.g., Medicare benefits for Dual-Eligible Members).

The HOI Quality Review RN considers the member's medical condition when determining SFHP's response time. The HOI Quality Review 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 or Appeal.

If the HOI Quality Review RN determines the complaint is a Non-Clinical Grievance or a Non-Clinical Decline-to-File Grievance, they route it to the Customer Service (CS) Grievance Coordinator in SFHP's Care Management System. Non-Clinical Grievances

and Non-Clinical Decline-to-File Grievances do not involve aspects of clinical care and do not need clinical practitioner review.

Non-Clinical Grievances involving entities delegated for Grievances and Appeal processing, cultural and linguistic components, disability components, services carved out of Medi-Cal managed care, other health coverage, or allegations of provider directory inaccuracies may require additional classification and/or review. Refer to CS-13 for more information.

d. Investigation and Documentation of Non-Clinical Grievance

1. SFHP's Care Management System stores the documentation of the substance of Non-Clinical Grievance and actions taken to address the Non-Clinical Grievance. Hard copy files may be printed from SFHP's Care Management System.
2. SFHP maintains a written record for each Non-Clinical Grievance received, including:
    a. The date and time of the receipt of the Grievance
    b. The name of the member filing the Grievance and any authorized representatives
    c. The SFHP representative recording/intaking the Grievance
    d. A description of the complaint or problem
    e. A description of the action taken by SFHP to investigate and resolve the Non-Clinical Grievance
    f. The proposed resolution by SFHP
    g. The name of the SFHP staff responsible for resolving the Non-Clinical Grievance
    h. The date of notification to the member of the resolution.
3. The CS Grievance Coordinator researches and documents issues relevant to the Non-Clinical Grievance, under the supervision of the CS Manager. The CS Grievance Coordinator records all findings in SFHP's Care Management System. The findings are presented to the CS Grievance Team to ensure the resolution addresses all issues raised by the member in the Non-Clinical Grievance. The Chief Operations Officer is consulted on an as-needed basis.
4. SFHP fully delegates the Non-Clinical Grievance process to one (1) health plan, Kaiser Health Plan Foundation.
5. SFHP partially delegates the responsibility for processing Non-Clinical Grievances to Beacon Health Options ("Beacon"). Under partial delegation, SFHP requires Beacon to present all Grievances including Non-Clinical Grievances to SFHP's Grievance Review Committee ("GRC"). GRC reviews the Non-Clinical Grievance and proposed resolution letter to ensure that all non-clinical components of the Grievance are resolved.
6. Non-Clinical Grievances involving Carved Out Services and Other Health Coverages are reviewed by CS manager on a case-by-case basis to determine appropriate handling of the grievance.
7. The CS Grievance Coordinator is trained by the Program Manager, Population Health on cultural and linguistic requirements ensuring that they can identify any

cultural and linguistic issues raised in the Non-Clinical Grievance. The Program Manager, Population Health performs a review of all Non-Clinical Grievances involving cultural and/or linguistic concerns including alleged discrimination by SFHP staff to ensure accurate identification and resolution of issues. For more information, see HECLS Desktop Procedure (DTP).

8. Pursuant to CS-13, 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.
9. 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. Documentation of Non-Clinical Decline-to-File Grievance

1. Alike Non-Clinical Grievances, documentation of the substance of Non-Clinical Decline-to-File Grievances are stored in SFHP's Care Management System.
2. SFHP maintains a written record for each Non-Clinical Decline-to-File Grievance received, including:
    a. The date and time of the receipt of the Non-Clinical Decline-to-File Grievance
    b. The name of the member reporting the Non-Clinical Decline-to-File Grievance and any authorized representatives
    c. The SFHP representative recording/intaking the Non-Clinical Decline-to-File Grievance
    d. A description of the complaint or problem
    e. Date acknowledgement letter sent
3. The CS Grievance Coordinator sends a Decline-to-File Grievance acknowledgement letter to the member within five (5) calendar days of receipt. The letter encourages the member to contact SFHP if he/she/they wish to pursue the Grievance.

f. Acknowledgement

Unless otherwise specified, the following requirements apply to both standard and Expedited Non-Clinical Grievances:

1. Except for Expedited Non-Clinical Grievances, the CS Grievance Coordinator prepares and sends a written Acknowledgement Letter within five (5) calendar days of receipt of the Grievance. This Acknowledgement Letter 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 CS Grievance Coordinator.
2. The Acknowledgement Letter informs the member that they may submit additional information or documentation supporting their Non-Clinical Grievance.

The CS Grievance Coordinator may contact the member to allow the member the opportunity to present more information regarding the Non-Clinical Grievance.

3. If a member requested Expedited Review of a Non-Clinical Grievance, but the HOI Quality Review RN determines the Non-Clinical Grievance does not meet the criteria for Expedited Review, the HOI Quality Review RN notifies the member by telephone that the member's grievance will be processed within the standard timeframe of 30 calendar days from receipt. The HOI Quality Review RN informs the member of the right to concurrently notify the DMHC about the Grievance, and provides the member with DMHC's contact information. Within five (5) calendar days of receipt of the Non-Clinical Grievance, the CS Grievance Coordinator also sends the member an Acknowledgement Letter informing the member that their Grievance was received, that the Grievance was downgraded to a standard Grievance, and will be resolved within 30 calendar days ("Downgrade Acknowledgement Letter").
4. The Acknowledgement Letter and Downgrade Acknowledgement Letter includes:
    a. The 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. 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.
    c. Taglines in the top fifteen languages used in California informing the member how to obtain free interpreter services.
    d. SFHP's nondiscrimination notice.

g. Resolution

Unless otherwise specified, the following requirements apply to both standard and Expedited Non-Clinical Grievances:

1. The Non-Clinical Grievance is resolved when the Grievance has reached a final conclusion with respect to the member's submitted grievance, and there are no pending member Appeals within SFHP's Care Management System, including entities with delegated authority.
2. The disposition of the Non-Clinical Grievance is communicated through the Grievance Resolution Letter. The CS Grievance Coordinator drafts the Grievance Resolution Letter, which includes a description of the substance of the Non-Clinical Grievance and a clear and concise explanation of the findings and SFHP's decision. The CS Manager reviews all Non-Clinical Grievance Resolution Letters prior to mailing.
3. If the member presented multiple issues, the CS Manager ensures all issues are addressed in the resolution. The CS manager ensures that the person making the final decision for the proposed resolution of a Non-Clinical Grievance has not participated in any prior decisions related to the Non-Clinical Grievance.

4. SFHP's timeliness and notification standards consider clinical urgency. The CS Grievance Coordinator mails the Grievance Resolution Letter to the member within 30 calendar days of receipt of the Non-Clinical Grievance.
5. The Grievance Resolution Letter includes:
    a. The 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.
    c. Taglines in the top fifteen languages used in California informing the member how to obtain free interpreter services.
    d. SFHP's nondiscrimination notice.
6. If resolution cannot be provided within the required timeframe, the CS Grievance Coordinator contacts the member to notify them of their right to contact DMHC and pending status of the grievance investigation and resolution.

III. Expedited Non-Clinical Grievances

The following requirements apply to Expedited Non-Clinical Grievances only:

1. Pursuant to CS-13, HOI Quality Review RN determines that a Non-Clinical Grievance requires Expedited Review if it involves involving 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. Pursuant to CS-13, members requesting Expedited Review of a Grievance are immediately informed of the right to contact the DMHC about their Grievance.
3. Expedited Non-Clinical Grievances are tracked and documented in SFHP's Care Management System. The CS Grievance Coordinator investigates the Non-Clinical Grievance under the supervision of the CS Manager.
4. The CS Grievance Coordinator consults with other staff responsible for the areas of service related to the Non-Clinical Grievance, as needed. The total time permitted for an Expedited Review is 72 hours (including the specific time the Appeal was received by SFHP).
5. The CS Grievance Coordinator communicates the disposition of the Non-Clinical Grievance via telephone and in writing in a Grievance Resolution Letter within 72 hours of receipt of the Non-Clinical Grievance.
   The CS Grievance Coordinator notifies the Supervisor, Regulatory Affairs, or designee, of receipt and resolution of an Expedited Non-Clinical Grievance. The Supervisor, Regulatory Affairs, or designee, provides a written statement to the DMHC about the disposition or pending status of the Expedited Non-Clinical Grievance within three calendar days of receipt of the Grievance.

IV. State External Review of a Non-Clinical Grievance

1. SFHP has one internal level of Grievance resolution. Members may contact SFHP Customer Service to have a previously issued resolution for a Non-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 SFHP's decision on the Non-Clinical Grievance, members may seek external review of their Non-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. The Supervisor, Regulatory Affairs, or designee, is responsible for coordinating responses to DMHC about IMRs and Consumer Complaints per CRA-24.
3. Medi-Cal members may contact the State Ombudsman's Office toll-free at 1-888-452-8609 for assistance with a Non-Clinical Grievance.
4. The Grievance Resolution Letter informs members about how to contact DMHC and/or the State Ombudsman's Office.
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.

V. Oversight Roles and Responsibilities

The Chief Operations Officer has primary responsibility for SFHP's Non-Clinical Grievance process and system.

The Manager, CS oversees the Non-Clinical Grievances and Non-Clinical Decline-to-File Grievance processes, reviews Non-Clinical Grievance and Non-Clinical Decline-to-File Grievance cases regularly with the CS Grievance Coordinator and provides advice on the investigation and resolution.

The Director, Claims, Customer Service, and Member Eligibility Management reviews Non-Clinical Grievance and Non-Clinical Decline-to-File Grievance data and reports, provides advice on resolution when needed, and provides final resolution on Non-Clinical appeal to the resolution made by Customer Service Manager.

The Grievance Program Leadership Team (PLT) meets quarterly, reviews a report of Grievance operational data, reviews aggregate data for trends and makes recommendations for interventions when opportunities for improvement are identified.

MONITORING

1. On a quarterly basis, the Manager, Customer Service runs a report of all Non-Clinical Grievances, Non-Clinical Decline-to-File Grievances, and Exempt Grievances. The Manager, Customer Service identifies trends in the data by Grievance category. The Manager, Customer Service shares findings with the

Chief Operations Officer and Director, Customer Service, Claims and Member Eligibility Management to discuss and address concerns and potential opportunities for improvement.

2. Grievance PLT reviews the quarterly report for Non-Cinical Grievances, Non-Clinical Decline-to-File Grievances, and Exempt Grievances, and makes recommendations for interventions when opportunities for improvement are identified.
3. 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.

DEFINITIONS

Administrative Appeals: an appeal of a decisions that are not about coverage or medical necessity. Administrative Appeals are subject to the requirements in NCQA RR 2. SFHP classifies and processes Administrative Appeals as Clinical or Non-Clinical Grievances. Please see policies and procedures 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. Appeals are subject to the requirements in NCQA UM 8 and UM 9.

Clinical Grievance: 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)

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.

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 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, 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.

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: 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)

- Complaints alleging discrimination by SFHP staff

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

Potential Quality Issue (PQI): potential issues with the quality of care or service delivered by a practitioner. SFHP provides a mechanism for peer review for PQIs in the form of a committee that meets to evaluate the need to alter the practitioner's participation in its health care delivery system based on evidence of serious quality deficiencies. The Plan also provides reports to the Medical Board of CA and other reporting agencies as required. PQIs include provider preventable conditions (PPC). As defined by federal regulations, PPCs are healthcare acquired conditions (HCAC) in inpatient hospital settings, as well as other provider-preventable conditions (OPPC) in all healthcare settings.

AFFECTED DEPARTMENTS/PARTIES

Access Compliance Committee (ACC)
Claims
Clinical Operations
Compliance & Regulatory Affairs
Customer Service
Delegated Group
Health Outcomes Improvement
Network Provider
Pharmacy Services
Provider Network Operations

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. CLS-02 Use of Interpreter Services and Bilingual Staff
2. CRA-24 Responding to State Inquiries about Member Complaints
3. CS-13 Member Grievances and Appeals: Rights, Intake and Case Creation
4. Decline-to-File Grievance Acknowledgment Letter
5. DTP HECLS
6. Grievance Acknowledgment Letter
7. Grievance Downgrade Acknowledgment Letter
8. Grievance Resolution Letter
9. QI-06 Clinical Member Grievances
10. QI-17 Member Appeals

REVISION HISTORY

Effective Date: July 2, 2019
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REFERENCES

1. Code of Federal Regulations, Title 42, Section 438.406 (b)
2. DHCS All Plan Letter 14-013 Grievance Report Template
3. DHCS All Plan Letter 17-006 Grievance and Appeal Requirements
4. 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
5. NCQA Standards RR 2 Policies and Procedures for Complaints and Appeals
6. Title 22, California Code of Regulations, Section 53858, 53893, 51014
7. Title 28, California Code of Regulations, Section 1300.68
8. Welfare and Institutions Code 10961