CENCAL HEALTH POLICY AND PROCEDURE	
Title: Member Grievance and Appeals System	**Policy No. :** MS-20
Department: Member Services	
Effective Date: July 1, 2017	**Revised Date:** June, 10, 2019
Cross Reference:	**Annual Review Date:**
Director: Eric Buben Interim Director of Member Services	**Director Signature and Date:** 7/8/19
Chief: Paul Jaconette Chief Operating Officer	**Chief Signature and Date:** 7/10/19

I. Purpose

CenCal Health's Member Grievance and Appeal (G&A) System establishes organizational accountability and responsibility for identifying, evaluating, and resolving member Grievance and Appeals.

II. Policy

CenCal Health maintains a member grievance and appeal system to ensure member grievances and appeals are responded to, and resolved, in a timely and appropriate manner. This Grievance and Appeal System (G&A) allows the Plan the opportunity to provide customer service recovery, enable the member, or their authorized representative the opportunity to grieve regarding a provider, service or benefit, and to disagree with the Plan's decision regarding the authorization process.

CenCal Health also tracks and trends member grievances and appeals to identify and correct any systemic problems with:

- Contracted Physicians/Specialists;
- Facilities providing medical care and services to health plan members;
- Health plan services to members.

All CenCal Health staff has a responsibility to inform members, parent/guardians of minor members of their right to:

- File a grievance or appeal without fear of sanctions, penalties, or interruption of care;
- Provide information about their grievance or appeal either in writing, in person or to a Member Services Representative by calling CenCal Health's toll-free telephone number;

- Assurance from CenCal Health that there is no discrimination or retaliation against a member or subscriber (including cancellation of the contract) on the grounds that they filed a grievance.

All Member Services staff involved in the receipt of a grievance or appeal have the responsibility to:

- Document all grievances and/or an appeal into CenCal Health's on-line tracking system as soon as either is identified. The on-line tracking system populates from the HIS eligibility data and provides for other demographic information of the member such as aid code and SPD identification, for appropriate reporting and compliance with regulatory and contract requirements.
- Immediately alert the appropriate G&A staff of any grievance or appeal requests that may require an Expedited Review pursuant to the G&A training manual.
- **All** Grievance and Appeal cases with the initial documentation of member's issues are forwarded to the Plan's Health Services QI nurse reviewer within two (2) business days of receipt if not an expedited request (immediately) from member or provider on their behalf. This process facilitates the review of documentation by the clinical nurse reviewer to ensure guidance regarding appropriate coding of case by the G&A coordinator and the procurement of appropriate medical records, chart notes and associated documentation to be requested for review by the Plan's physician reviewer.

CenCal Health retains responsibility for the quality of the Member Grievance and Appeal System and does not delegate this responsibility to its provider network. Mental/Behavioral Health grievances and appeals regarding outpatient mild to moderate services are processed by CenCal Health's contracted Mental/Behavioral Health Provider, The Holman Group, and collaboratively resolved through The Holman Group's Grievance Committee.

Grievances and appeals received by CenCal Health staff from its members regarding Specialty Mental Health (also known as Mental Health Plans, or "MHP") provided through Santa Barbara County Alcohol, Drug, and Mental Health Services (Santa Barbara Wellness), and Mental Health Services of San Luis Obispo County (MHS-SLO) are forwarded to these agencies immediately and the member is advised accordingly. If the member wishes to provide the Plan's Member Services Representative (MSR) with full details of their grievance or appeal, the MSR will document their issue, offer a warm transfer to the appropriate agency, and advise the member that the Plan will be forwarding their grievance or appeal to the appropriate entity for resolution. In addition, the grievance or appeal will be forwarded to the Plan's G&A staff to ensure that the member's concern is addressed by the appropriate mental/behavioral health entity.

III. Procedure

A. Initiation of a Grievance or Appeal

CenCal Health's Member Grievance and Appeal System procedure and process allows an appeal or grievance to be initiated from any of the following:

- A member or their appointed representative (if the member wishes to have a representative act on their behalf regarding the appeal or grievance, he/she must complete or send their Appointment of Representative Form if not on file with the Plan);
- A provider on behalf of a member, with member's participation and signed permission.

B. Notification of How to File a Grievance and Appeal

Member Notification:

- **EOC/Member Handbook:** CenCal Health sends new members a current Evidence of Coverage and Disclosure (EOC) Member Handbook and replacements upon request. Within this EOC/Member Handbook, the grievance and appeal process is explained. Members or their appointed representative may utilize the Plan's website using a grievance or appeal form; or they can request a grievance or appeal form from the provider's office, or they may request a form from the Plan directly if they wish to put their request in writing. Members may also call the Plan's Member Service Department's toll-free telephone number to speak with an MSR who will assist them with filing their grievance or appeal.

- **Internet Notification:** CenCal Health's website (www.cencalhealth.org) informs Internet users of how to file a grievance or appeal either by contacting Member Services through the toll-free telephone number, or by utilizing the website to file their grievance or appeal online.

- **Annual Notification in Member Newsletter:** CenCal Health's member newsletter informs members of their Rights and Responsibilities which includes how they can file a grievance or appeal.

Provider Notification:

- **CenCal Health Member Grievance and System Policy and Procedure:** A copy of this policy and procedure is included in CenCal Health's Provider Manual to inform providers of procedures regarding how their patients are able to file grievances or appeals.

- **CenCal Health Grievance - Appeal Forms:** All CenCal Health provider sites are supplied with CenCal Health Grievance and Appeal Forms to assist members to file grievance or appeals or for providers to file on behalf of members that includes the member signature.

C. Grievance and Appeal Processing

1. Intake, Documentation and Registering of Member Grievance and Appeal

1.1 Grievance and appeals may be presented either through a telephone call, grievance or appeal form, or other correspondence. The Member Services Representative (MSR) is the primary intake for member generated grievances and appeals. The MSR obtains the necessary information from the member, their appointee, or provider for appeals (with the members signed permission) on their behalf, and confirms that the member wishes to file a grievance or appeal. All Grievance and Appeals are entered into the Grievance and Appeal On-Line Tracking System. As noted within the definition section of CenCal Health's Policy, every G&A case is tracked by date and time of receipt, all activities such as research, clinical reviews with follow-up, outcomes, acknowledgement and final letters along with days aging are tracked and reported as required by state contract and regulatory guidelines.

1.2 Should a person other than the subscriber or member, provider, or appointed representative contact CenCal Health, the MSR will document the information presented. At no time will the MSR divulge a member's confidential information to the individual that files the complaint on behalf of the member. The MSR will refer the issue to the Member Services Supervisor, or designee, who will contact the member to validate the issue and ask if the member wishes to file a grievance or appeal.

1.3 If a grievance needs further information or clarification while the member is on the phone with the MSR, the MSR evaluates the member's responses to the following questions, documents responses, and provides assistance as defined below:

- Does the member need care and if so is the need immediate or urgent? If so, the MSR will notify the appropriate resource, (i.e. – their supervisor for assistance, Health Services UM or CM department for clinical assistance in order to assist in the coordination of care.

- Does the member want to change to a new PCP while not in the middle of care? If so, the MSR would perform the PCP transfer for the member and continue to complete the documentation of the member's issue.

- Does the member want to change to a new PCP while in the middle of care? If so, the MSR will discuss continuity of care issues with the member, and if necessary, will contact the PCP with the member's permission to validate that the transfer will not disrupt continuity of care. If the member does not wish to involve the PCP or the provider who is rendering care to the member

in whom they are filing the grievance about, the MSR will contact the Health Services UM, CM department clinical staff to obtain direction and assistance with the potential continuity of care.

- Did the member obtain services outside the health plan? If so why? Are they still under care of a non-participating provider? What are they receiving services for and why did they go out of plan or network? The MSR should obtain the date of services, the physician name(s), address(s) and telephone number(s), if possible, and inquire if there are medical records that need to be obtained and any claims or billing statements that may also need to be addressed.

- All G&A documentation from the MSR should have the five (5) main questions answered within the documentation: 1) Who, 2) What, 3) When, 4) Where, and 5) Why.

1.4 Upon receipt of a written grievance or appeal, the Grievance Coordinator will call the member, or their appointed representative, within one business day to discuss their grievance or appeal. All requests for CenCal Health Grievance and Appeal Forms are to be mailed no later than the next business day from the date of the request. All grievances and appeals received either written or via the toll-free telephone number for the Member Services Department, are entered in CenCal Health's on-line tracking system with the date the grievance or appeal was received. This documentation is date and time stamped in the on-line system. Through e-mail notification, the MSR notifies the Member Services Grievance and QI Manager, or designee that a complaint or appeal was received and entered in CenCal Health's on-line tracking system.

2. Investigation and Research of Member Grievance and Appeal

2.1 **Member Services Grievance Coordinator Research** - The Member Services Grievance Coordinator, reviews the documentation and contacts the appropriate provider office(s) to validate date(s) of service and other information given by the member. Behavioral Health grievances and appeals are forwarded directly to the Member Services Grievance-QI Manager for review and forwarding on the Mental/Behavioral Health Provider for research and resolution with the member or their appointed representative.

2.2 **Member Services Grievance Coordinator Research** - The Member Services Grievance Coordinator reviews all grievance documentation and research and assigns a code to categorize each grievance or appeal. This coding is based solely on the member perception of their issue if a grievance and not on any formulation of the resolution or outcome that has its own outcome coding.

The Member Services Grievance Coordinator reviews each grievance or appeal, including all information from the provider office(s) and any other pertinent research, and then makes a recommendation as to whether there is, or is not, a clinical component to the grievance. The Member Services Grievance Coordinator then refers the case to the Health Services QI Manager and within two (2) calendar days for verification of the accuracy of the Member Services Grievance Coordinator's coding for clinical review necessity and confirmation of appropriate medical records, charts and other documentation that the Grievance Coordinator will be obtaining for physician review. If the appeal is regarding the discontinuance of benefits, the plan must provide for the continuation of noted denied benefits until the resolution of the appeal has been determined. The Health Service QI Manager will coordinate these services with the Health Services UM staff.

Mental/Behavioral Health G&A - The Member Services Grievance-QI Coordinator summarizes and forwards documentation of all mental/behavioral health clinical and non-clinical grievances or appeals to ADMHS, MHS of San Luis Obispo (MHS-SLO) for specialty mental health services if the grievance or appeal is pertaining to them and specialty mental health services. The same process applies for grievance and appeals pertaining to the Holman Group regarding one of their providers for outpatient mild to moderate mental health or behavioral health services for ASD. Within one (1) business day, the ADMHS, MHS - SLO QA Manager or the Holman Grievance Manager will acknowledge receipt of the complaint by secure e-mail to the Member Services Grievance-QI Coordinator. The QA Managers for ADMHS, MHS -SLO or The Holman Group researches and resolves grievances and appeals directly with the member.

2.3 **Verification of Grievance and Appeal Coding** - Every grievance and appeal is reviewed by a Health Services QI Manager who is a Registered Nurse with an active license to practice nursing in California. For each grievance and appeal case, the Health Services QI Manager verifies the appropriateness of the Member Services Grievance Coordinator's coding determination. This verification is based on clinical experience and application of clinical criteria. The Health Services QI Manager notifies the Member Services Grievance Coordinator of his/her decision, and determines whether any additional information is required to process the grievance or appeal. Additional information may or may not include medical records.

If the Member Services Grievance Coordinator categorizes a grievance or appeal as non-clinical, the Health Services QI Manager reviews the grievance or appeal documentation on CenCal Health's on-line tracking system and verifies that the grievance or appeal has no clinical component within two (2) business days of receipt of the grievance or appeal. All prior authorizations that have resulted in an Adverse Benefit Determination that would include TARs,

RAFs, MRFs are automatically considered clinical review necessity and process appropriately for review by a physician reviewer not involved in the original decisions. If the Health Services QI Manager determines that the grievance may involve a clinical concern, the Health Services QI Manager will notify the Member Services Grievance Coordinator. The Member Services Grievance Coordinator will correct the coding and proceed, if necessary, with the collection of documentation required by Health Services to process the grievance for clinical review by a designation physician reviewer.

Non-Clinical Review Process - The Member Services Grievance-QI Manager reviews and oversees all grievance and appeal documentation and research. The Member Services Grievance-QI Manager completes the review, documents findings and follows-up with appropriate staff when necessary to address identified quality improvement opportunities regarding quality of service issues.

2.4 **Clinical Review Process** - When the Member Services Grievance Coordinator completes the required documentation, a complete packet, including all pertinent information needed for the review by a physician reviewer, is presented to the Health Services QI Manager.

For grievances that require a physician reviewer, the Health Services QI Manager reviews the completed packet, and prepares a review summary and recommendation for the Health Services physician reviewer. The physician/ physician designee reviews the packet and directs appropriate departments to perform follow-up when necessary to address identified quality improvement opportunities. All research of clinical issues that are part of the physician reviewer's findings are considered peer review protected via state statute.

For clinical reviewed appeals, the physician reviewer must be different than the physician who reviewed the initial request. The physician reviewer will consult with or direct the review, when necessary, to a practitioner in the same or similar specialty who typically treats the condition, and directs appropriate departments to perform follow-up when necessary to address identified quality improvement opportunities.

If the Health Services physician reviewer identifies a quality of care concern, and determines that the grievance constitutes a sentinel event (a sentinel event is an unexpected occurrence involving death or serious physical or psychological injury), or there is significant variation from accepted standards of care, these incidents will be submitted and reviewed by the CenCal Health Peer Review Committee. This committee will make a determination and advise if there is a need for potential further follow up with the physician involved.

The Chairman of the Peer Review Committee is to assure that the case is evaluated thoroughly, there is adequate input to the discussion, a reasonable effort is made to obtain the facts of the matter, and that the case is brought to its finality and signed off by the Chair of Peer Review.

2.5 **Expedited Appeal Process -** The expedited appeal process is applicable only to pre-service requests. The Member Services Grievance-QI Manager reviews members' or providers' requests on behalf of the member with their permission for expedited appeals immediately upon receipt and forwards to the Health Services QM Specialist for review to determine if requests meet criteria for expedited appeal.

2.6 **Experimental/Investigational Clinical Appeal Process -** Applicable to CenCal Health's Knox-Keene licensed programs; Knox-Keene 1374.30-34. If CenCal Health has denied a treatment procedure or service as being experimental or investigational, members may request a face to face meeting or hearing with CenCal Health's Medical Director and/or their physician designee to be held within five (5) calendar days. Otherwise the appeal is processed within the normal thirty (30) calendar day time frame. These denials are subject to the Independent Medical Review process and members will be notified of their right to request this process with the appropriate IMR Form and envelope within five (5) calendar days of the health plan's decision to deny. Members are not required to first file an appeal with CenCal Health before requesting an Independent Medical Review.

3. Notification to Member of Disposition of Grievance and Appeal

The Member Services Grievance Coordinator acknowledges receipt of members' grievance and appeals, in writing, within five (5) calendar days. Members may submit additional comments, documents and other information relating to their grievance or appeal. The acknowledgement letter is sent on Plan Letterhead and contains the date the grievance or appeal was received, a summary of the issue, advising them that their issue will be resolved within thirty (30) calendar days, the Grievance Coordinator's name, phone number and the Plan address noted on the bottom of the official Plan Letterhead.

The Health Services physician reviewer notifies the Member Services Grievance Coordinator in writing of the completion of each clinical review for grievances and appeals.

The Member Services Grievance Coordinator notifies members, in writing that CenCal Health has finished its review of their grievance no later than thirty (30) calendar days from its receipt.

For clinical appeals, the Health Services QI Manager notifies the Member Services Grievance Coordinator of the Chief Medical Officer/ physician designee's appeal decision and provides the documentation and/or reason for the denial to be included in the final letter to the member, which are noted to be Notice of Appeal Resolution (NAR). Elements for this letter are attached with this Policy and Procedure which also includes the member's right to a state hearing. The Member Services Grievance Coordinator prepares the final resolution letter, obtains the Chief Medical Officer/ Physician Designee's signature, and mails the member the appeal decision, in writing, no later than thirty (30) calendar days from receipt. Should the appeal process require more time due to additional information needed by the physician reviewer to complete their review or the member has requested an extension, the appeal must be resolved no later than fourteen (14) additional days. When there is an extension based upon the Health Plan's need for more information, the member must be notified orally and in writing within two (2) calendar days and of their right to file a grievance if they disagree with the Plan's need to extend the time frame for resolution. If the Plan fails to adhere to the noted time requirements, the member is deemed to have exhausted the Plan's appeal process and may initiate the State Hearing Process within 120 calendar days of the Plan's failure to comply with the regulations noted above.

The member is also notified of their right to receive, upon request, reasonable access and copies of all documents relevant to their appeal in accordance with HIPAA requirements noted in the Member Handbook at no cost. Requests for documents must be approved by CenCal Health's Chief Medical Officer and the HIPAA Privacy Officer. The member is also notified of their right to request a copy of the actual benefit provision, guideline, protocol and other similar criterion on which the appeal decision was based and they may obtain a list of titles and qualifications of individuals participating in the appeal review.

If the appeal decision is favorable to the member, Health Services UM, CM or clinical designee will ensure that the authorization for services is approved in the HIS that same business day and will coordinate with the Grievance Coordinator in order to ensure the health care services are scheduled as promptly and as expeditiously as the member's condition requires. Should the member require services within seventy-two (72) hours, this will be coordinated with the appropriate physician, facility or pharmacy. The member is notified both orally and in writing via the NAR template language requirements.

For Expedited appeals, within seventy-two (72) hours of receipt, the Health Services QI Manager notifies the Member Services Grievance Coordinator of the physician reviewer or physician designee's determination if case does/does not meet expedited criteria and the Member Services Grievance Coordinator notifies the member by telephone, and in writing, of the outcome of CenCal Health's expedited review determination. Written notification is sent by certified U.S. mail.

If the request did not meet expedited criteria for handling, the standard 30-day appeal review is initiated.

For Knox-Keene Licensed programs, Experimental/Investigational appeals, within five (5) calendar days of CenCal Health's decision to deny, terminate or modify, the Health Services QI Manager notifies the Member Services Grievance Coordinator who notifies the member in writing, of the outcome of CenCal Health's review. Written notification is sent by certified U.S. mail.

Mandated Language with Member Notification

For Knox-Keene Licensed programs, DMHC mandated language, including the DMHC's toll-free telephone number, the DMHC's TDD line for the hearing and speech impaired, CenCal Health's telephone number, and the DMHC's internet address, is included on CenCal Health's website and in all of the following documents:

- CenCal Health's contracts with its providers;
- All Evidences of Coverage/Member Handbooks;
- CenCal Health's Member Grievance and Appeal System Policy and Procedure (refer to Attachment 1, which also includes the Independent Medical Review Form with envelope);
- Grievance and Appeal Forms, and
- All written responses to grievances and appeals, and
- All written notices to enrollees required under the grievance process of CenCal Health, including any written communications to an enrollee that offer the enrollee the opportunity to participate in CenCal Health's grievance process.

Pursuant to Title 22 requirements, Department of Health Care Services (DHCS) and Title 42, CFR, mandated language is included in all of the letters and/or member notification listed above.

4. Department of Social Services (DSS) State Hearings

4.1 The Department of Social Services is the county agency that determines eligibility for public assistance programs, such as Medi-Cal, Cal Works, Aid to Families with Dependent Children, Food Stamps, and general assistance. Members that disagree with the health plan's decisions regarding a denial, termination, or modification of a request for services for prior authorization, may request a State Hearing within 120 calendar days from the date of the Plan's Notice of Appeal Resolution Letter. In the event that the Plan denial is regarding a discontinuation of a benefit, the Plan will provide for the continuation of benefits those services pending the State Hearing resolution.

4.2 The Director of Legal Affairs is CenCal Health's primary contact for State Hearing notification. Upon receipt of the State Fair Hearing request, the Director of Legal Affairs will review the case, prepare a position statement with the Health Services physician reviewer, and represent the health plan at the State Fair Hearing with appropriate clinical staff.

5. Confidentiality – HIPAA Privacy and Security Standards

5.1 CenCal Health has adopted and implemented Health Plan confidentiality policies and procedures to include the HIPAA Privacy Standards that were effective April 14, 2003, and Security Standards effective April 2005. CenCal Health's Privacy Program is a comprehensive process that addresses all Privacy Standards and interrelating Security Standards. All minimum necessary precautions, as noted in the HIPAA Privacy and Security Standards, have been implemented. CenCal Health membership is notified of these standards through the HIPAA Notice of Privacy Practices.

5.2 CenCal Health's provider and Business Associate contracts specify expectations regarding the confidentiality of protected member information.

5.3 Consistent with HIPAA Privacy standards, CenCal Health will only request the minimum pertinent medical records needed by appropriate licensed clinical professionals for review.

6. Oversight - Health Plan Administration and Quality Assessment and Improvement Program (QAIP)

6.1 The Chief Medical Officer is responsible for the clinical direction and clinical oversight of this Member Grievance and Appeal System.

The Chief Operations Officer (COO) is responsible for oversight of the Member Grievance and Appeal System and the operational implementation of CenCal Health's policies and procedures. The Chief Operations Officer also submits monthly Member Grievance System statistics to the Board of Directors.

The Member Services Director is responsible for the regulatory and contractual compliance and reporting of the Member Grievance and Appeal System.

6.2 The Chief Executive Officer and the Chief Medical Officer are responsible for the oversight of the Plan's Quality Assessment and Improvement Program (QAIP), of which the Member Grievance and System is a component. The QAIP describes CenCal Health's Quality Management Committee structure, and within that structure, the Member Grievance and Appeal System processes. The QAIP is presented annually to the Board of Directors for their review and approval.

6.3 All Member Grievance and Appeal System grievance and appeal closed files are stored in locked cabinets for a period of not less than five (5) years.

D. Staff Education

Member Services: Member Service Representatives receive a training manual dedicated to the Member Grievance and Appeal System and its policy and procedure. Job aids and training regarding appropriate documentation and how to ask appropriate questions relating to grievances and appeals are also reviewed with new MSRs and staff on a regular basis. The Member Services Director and the Grievance QI Manager are knowledgeable of the Knox-Keene Act, Section 1368, Title 28 1300.68, NCQA and contractual requirements with the State Contract. The Member Services Grievance-QI Manager provides the daily oversight of the Grievance and Appeal Process while the Member Services Training Manager provides the in-service trainings to CenCal Health's Member Services Representatives on a regular basis. The Member Services Grievance-QI Manager and the Call Center Manager also monitor the intake, documentation and the necessary coordination of care within the grievance and appeal process by Member Services Representatives, and monitors resolution times for grievance and appeals as a critical indicator for regulatory compliance and satisfaction for CenCal Health Members. The Member Services Director provides oversight of the necessary reporting to the quality committees, Board of Directors and DHCS monthly and quarterly grievance and appeal reporting.

Provider Services: Provider Service Representatives receive job aids and training regarding the Member Grievance and Appeal System. This department also receives the training manual dedicated to this process. Provider Services is a critical component of the Member Grievance and Appeal System when follow up with providers is necessary for continual quality improvement.

Health Services: Health Services Quality Management Staff is knowledgeable about current Medi-Cal benefits, the Knox-Keene Health Care Service Plan Act of 1975, Title 28, Title 22, and the contractual obligations regarding grievance and appeals along with other relevant regulations, and CenCal Health's provider network. The Health Services QM staff has a cooperative working relationship with the Member Services Director and the Grievance-QI Manager.

E. Monitoring

Monitoring of the Grievance and Appeal System process is performed through CenCal Health's Quality Committee Structure. CenCal Health's Chief Medical Officer provides oversight and guidance for the process.

The Member Support Committee reviews all service and access indicators relating to aggregate Member Grievance and Appeal System data. These include compliance with resolution time frames, and aggregate data by type and outcome. This data is monitored quarterly for trends and any systemic issues that might be identified. This data includes Seniors and Persons with Disabilities, OTLIC, Behavioral Health, Mental Health Grievance and Appeal Grievances for appropriate reporting to DHCS-MMCD.

The Network Management Committee reviews quarterly Grievance and Appeal System data relating to Access and Availability issues. The Network Management Committee may determine to have the Provider Advisory Committee review any systemic issues the committee has identified that relate to access and availability issues.

This data is also presented to the Healthcare Operations and Quality Improvement Committees and is included in the monthly operational report to the Board of Directors. The Member Services Director reports to the Chief Operations Officer all grievance and appeal documentation and reports for review of aggregate data and compliance with timeliness standards as part of an operations report to CenCal Health's Board of Directors.

IV. Definitions

Grievance: A grievance is an oral or written expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include but are not limited to, quality of care or services provided, aspects of interpersonal relationships with providers, their staff, Plan staff such as rudeness, administrative policies, procedures and protocols by the Plan and the member's right to dispute an extension of time proposed by the Plan to make an authorization decision. Inquiries are a request for information or assistance that does not include expressions of dissatisfaction.

Members shall not be discouraged from filing grievances. A member need not use the term or word "grievance" for a complaint to be documented as an expression of dissatisfaction and therefore, a grievance. If a member expressly declines to file a grievance, the issue causing the dissatisfaction shall be deemed a grievance. The member's identity for these grievances are protected.

Non-clinical grievances: Are expressions of dissatisfaction that do not have a clinical component, including but not limited to unsatisfactory interaction with staff or provider, condition of a provider's office, and/or other administrative issues with a provider, vendor or CenCal Health.

Clinical Grievances: Are directly related to the appropriateness of medical care, including but not limited to issues of patient safety and quality of care. A clinical review by a licensed health care professional physician reviewer is required to process the grievance.

Standard Grievance Time Frame: There is no time limit for members to file a grievance with the Plan. Standard Grievance resolution to member is within thirty (30) calendar days.

In the event a resolution is not reached within thirty (30) calendar days, the Plan shall notify the member in writing of the status of the Grievance and the estimated date of resolution, which shall not exceed fourteen (14) calendar days.

Exempt Grievances: Grievance received through the Plan's call center 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 acknowledgment and response. These grievances are tracked with the same information that is captured in a standard grievance on the on-line Grievance and Appeal Tracking System and are incorporated and reported quarterly to the Department of Health Care Services. Refer to G&A Tracking System definition.

Expedited Grievances: Grievances that involve imminent and serious threat to the health of a member, including, but not limited to, severe pain or potential loss of life, limb or major bodily function that do not involve the appeal of an Adverse Benefit Determination, yet are urgent or expedited in nature are to handled and resolved within 72 hours.

Clinical Review: A clinical review is defined as a review of the clinical facts, circumstances including medical charts of a grievance or appeal by a licensed health care professional with appropriate education, training and expertise. Clinical reviews are undertaken as part of CenCal Health's Grievance and Appeal System to resolve clinical complaints or appeals and evaluate quality of care. This review shall consist of pertinent medical records and/or other documentation that is determined as necessary as part of the research and evaluation based on the member's grievance or appeal.

All grievance and appeal documentation of the member issue is reviewed by the Plan's designated clinical staff that is the QM Nurse, to ensure appropriate categorization and research with appropriate records are requested for review by the physician reviewer

Non-Clinical Review: A non-clinical review is defined as a review of the facts and circumstances of a grievance or appeal that does not contain a clinical component. Non-clinical reviews are performed by qualified staff. CenCal Health designates the Member Services Grievance-QI Manager to resolve non-clinical grievance and appeals, and the Director of Member Services in their absence, or should the Grievance and QI Manager need assistance with the resolution of the grievance or appeal. No medical records are necessary to complete non-clinical reviews as there is no clinical component identified in the grievance or appeal.

Initial Determination (Pre-Authorizations): An initial determination is defined as a decision rendered by CenCal Health to carve out, deny, modify, terminate, delay or approve a proposed treatment, procedure or prescription based upon medical necessity or the determination that the requested services was not a covered benefit. Initial determinations are communicated to providers and members by CenCal Health via written notification called of a Notice of Action (NOA), for determinations of Treatment Authorization Requests (TAR), Prior Authorizations (PA), or Medical Request Forms (MRF).

Adverse Benefit Determination: Includes all existing elements of "Action" and includes determinations involving medical necessity, appropriateness, setting, covered benefits, and financial liability. An "Adverse Benefit Determination" is defined to mean any of the following actions taken by CenCal Health Plan:

- The denial or limited authorization of a requested service including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of a payment for a service;
- The failure to act within the required timeframes for standard resolution of Grievances and Appeals;
- The denial of the beneficiary's request to obtain services outside the network
- The denial of a beneficiary's request to dispute financial liability.

Notice of Action: Is a formal letter informing the Plan member of an Adverse Benefit Determination. Members may request at no charge copies of all documents and records relevant to the Plan decision including criteria and/or guidelines used to make the decision or determination.

Appeal: An appeal is a dispute in which the member or their appointed representative (or a provider on behalf of a member with the member's written permission) requests a reconsideration or review of an initial determination that resulted in an Adverse Benefit Determination, such as a denial, carve out, modification, termination or delay of a health care service. The member has sixty (60) calendars days from CenCal Health's initial determination to submit their appeal request. Members may file their appeal orally by contacting the Plan's call center. The Plan shall request that the member's oral request for a standard appeal be followed-up by written and signed confirmation from the member or their appointed representative. The Grievance & Appeal Coordinator will provide an appeal form documenting the member's appeal request to the Plan's call center that will be included in the appeal acknowledgement letter accompanied by a postage paid return envelope. Non-receipt of the signed appeal form will not delay nor will the Plan dismiss the member's appeal. Providers appealing on behalf of members require written consent from the member. Members must also exhaust the Plan's appeal process (only one level) prior to requesting a State Hearing. Members may request a State Hearing within 120 calendar days from the date of the Plan's written Appeal resolution letter known as a Notice of Appeal Resolution (NAR).

Non-Clinical Appeals: A member's request for a review of a CenCal Health decision that involved non-clinical criteria such as request for (reimbursement for routine care received out of state, not a covered benefit (such as OTC items).

Clinical Appeals: A member's request for review of a service denial, delay, deferral or modification of a pre-service request, or benefit coverage, in which the denial determination was based on clinical criteria, medical necessity or not a covered benefit.

Notice of Appeal Resolution Letter: Is the written response to a member's appeal. This letter shall contain the results and date of CenCal Health's review and resolution to their appeal.

If the appeal resolution upholds the Plan's original determination, the following applies:

- If the Plan's determination is based in whole or in part on medical necessity, the Plan shall include in its response the reasons for it determination and clearly state the criteria, clinical guidelines, or medical policies used in reach the determination.
- If the Plan's determination specifies the requested services is not a covered benefit, the Plan shall include in its written response the provision in the DHCS contract, Evidence of Coverage-Member Handbook that excludes the services. The response shall identify the document and page where the provision is found, direct the member to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested.
- The Notice of Appeal Resolution MUST contain "Your Rights" Attachment. (see DHCS template of NAR).

If the appeal resolution overturns the Plan original determination in favor of the member, the following applies:

- The Notice of Appeal Resolution shall include the resolution and date of completion. The Plan shall also ensure the written response contains a clear and concise explanation of the reason, including the reason for why the decision was overturned. (See DHCS template of NAR for overturn language). Please refer to the procedure section of this document for additional process for the ensuring services are authorized appropriately.

Standard Appeal Time Frame: The Plan resolves standard appeals within thirty (30) calendar days. In the event a resolution is not reached within thirty (30) calendar days or the member requests an extension, the Plan shall notify the member both orally, and in writing within 2 calendar days) which shall not exceed fourteen (14) calendar days. If the member disagrees with the Plan's extension of the appeal, they must be informed of their right to grieve the extension. If the Plan fails to adhere to the notice and time requirements for the extended timeframe for resolution, the member will be deemed to have exhausted the Plan appeal process and may initiate a State Hearing. The Plan has only one level of appeal.

Expedited Review/Appeal: A member or their appointed representative may request a review of an Adverse Benefit Determination involving a denial, termination or

modification for health care services that they believe must be resolved within 72 hours as failure to do so could have an imminent and serious threat to the health of the member, including, but not limited to, potential loss of life, limb or major bodily function and severe pain. (Title 28, CCR, Section 1300.68.01 and the Knox-Keene Health Care Service Plan Act of 1975). Members are notified of the Plan's decision both orally and in writing.

Experimental and Investigational Appeal: (Applicable to CenCal Health's Knox-Keene Licensed programs; Knox-Keene 1370.4): An appeal for non-standard therapies and treatment options, submitted by a terminally ill member or a member that has a life-threatening or seriously debilitating condition. CenCal Health's Chief Medical Officer and/or their physician designee retain responsibility for determining if a treatment is experimental or investigational.

Grievance and Appeal (G&A) Tracking System: is the on-line tracking mechanism for all Plan grievance and appeal cases. This system tracks and date stamps all activities within the G&A process to include but not limited to; initial intake by Plan staff of the member's grievance and/or appeal that includes date stamping when the grievance and/or appeal is received and documented to final resolution and total days aging. Member demographic information, their ID number, an assigned G&A log number, name of provider involved, nature of the grievance or type of denial regarding an appeal and all research conducted by Plan staff. System also tracks all acknowledgement and final resolution letters and the date sent, internal workflows within the process between the G&A staff to and from Health Services staff, clinical reviews, physician reviewer's outcome and follow-up directions.

V. References

APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments

VI. Attachments

N/A