CENCAL HEALTH POLICY AND PROCEDURE (P&P)	
Title: Member Grievances	**Policy No.:** MS-22
Department: Member Services	
Cross Functional Departments: Provider Services, Medical Management, Quality	
Effective Date: 07/2023	**Last Revised Date:** 10/2023
P&P Require DHCS Approval? Y ☒ N ☐	
Director or Officer Signature: Eric Buben Director of Member Services	**Officer Signature:** Van Do-Reynoso, MPH, PhD Chief Customer Experience and Chief Health Equity Officer

I. Purpose:

To ensure CenCal Health's Member Grievance system establishes organizational accountability and responsibility for identifying, evaluating, and resolving Member Grievances.

II. Policy:

A. CenCal Health maintains a Member Grievance system to ensure Member Grievances are responded to, and resolved, in a timely and appropriate manner. This Grievance system allows the Plan the opportunity to provide customer service by enabling the Member, or their authorized representative, the opportunity to grieve regarding a provider, service, or benefit.

B. CenCal Health's Grievance system provides Members or their appointed representatives the right to submit Grievances, either verbally by phone, in person, or in writing about CenCal Health, Network Providers, care received, and any other expression of dissatisfaction not related to an Adverse Benefit Determination.

C. All Member Services staff involved in the receipt of a Grievance have the responsibility to:

1. Document all Standard and Expedited Grievances 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 demographic information of the member such as aid code and SPD identification, for appropriate reporting and compliance with regulatory and contract requirements.

2. Immediately alert the appropriate CenCal Health staff of any Discrimination Grievances that will require immediate forwarding to CenCal Health's "Discrimination Grievance Coordinator" for investigation outside of CenCal Health's standard Grievance process.

3. Provide Members with assistance in completing Grievance forms.
4. Coordinate with the Grievance & Appeals (G&A) Team to deliver all documents requested by a filing Member or their representative, that CenCal Health reviewers used to make a decision.
5. Coordinate auxiliary aid, translation of materials, alternative format selection needs or connect with interpreter services or provide CenCal Health's toll-free number for TTY/TDD 1-833-556-2560.
6. All Grievance cases with the initial documentation of Member's issues are forwarded to the Plan's Medical Management Team/ Licensed Clinical Professional reviewer within two (2) business days of receipt (unless the Grievance is an expedited request, which is forwarded 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 Member Services Grievance & Appeals Coordinator (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.

D. CenCal Health retains responsibility for the Member Grievance system and does not delegate this responsibility to its provider network.

E. Grievances 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 County Behavioral Wellness Department), 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, 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 to the appropriate entity for resolution. In addition, the Grievance 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.

F. Grievances received by CenCal Health staff from its Members regarding pharmacy benefits are no longer processed by CenCal Health. The new Department of Health Care Services (DHCS) Program in the State of California known as "Medi-Cal Rx" assumed grievance and appeal responsibilities on January 1, 2022.

III. **Procedure**:

A. Initiation of a Grievance

1. All Member Grievances are initiated by CenCal Health. The initial review policies and procedures are as outlined in Health & Safety Code section

1367.01 and included in CenCal Health's pre-service review process Policy & Procedure (HS-UM07_Pre-Service_Review).

2. CenCal Health's Member Grievance system procedure and process allows a Grievance to be initiated from any of the following:
    a. A Member or their appointed representative (if the Member wishes to have a representative act on their behalf regarding the Grievance, and he/she at minimum provides verbal authorization to file on the member's behalf or must complete or send their Appointment of Representative Form if not on file with the Plan);
    b. A provider on behalf of a Member, with Member's participation, which must include verbal or written consent if Member has granted provider the authority to act on their behalf in filing the Grievance; only then will the Grievance be initiated.
3. DHCS, through Medi-Cal Rx, has assumed the oversight and administration for Medi-Cal pharmacy benefits for all Medi-Cal beneficiaries in the State of California, and CenCal Health is currently not responsible for initiating Member Grievances related to Medi-Cal pharmacy benefits. CenCal Health will, however, provide Magellan Rx (the pharmacy benefits manager for Medi-Cal Rx) with any assistance requested to help in processing Member Grievances.
    a. If a Member calls CenCal Health to file a Grievance related to their pharmacy benefits, CenCal Health's Member Services Department will transfer the Member, or the appointed representative, to the Medi-Cal Rx CSC through Magellan Rx directly at 1-800- 541-5555, TTY 1-800-430-7077.

B. Intake, Documentation and Registering of Member Grievance

1. Grievances may be presented either through a telephone call, Grievance form, in-person, or other correspondence.
2. The MSR is the primary intake for grievances received via telephone. The MSR obtains the necessary information from the Member, their appointee, or provider (with the Member's verbal or written consent required before initiation of the Grievance filed by a provider) on their behalf and confirms that the Member wishes to file a Grievance. Members may present evidence, testimony, or make arguments etc., via phone call or in writing in support of their Grievance. All information gathered will be presented to the non-clinical or clinical reviewers at the time the investigation completes.
    a. Should a person other than the 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.

i. If a Grievance needs further information or clarification while the Member is on the phone with the MSR, the MSR evaluates the Member's needs, documents the discussion and responses, and provides assistance at the time of the call such as: changing a PCP, determining immediate health care needs, and providing guidance on how to obtain services, initiating continuity of care requests etc.

3. Upon receipt of a Grievance, the G&A Coordinator will call the Member, or their appointed representative, within one business day to discuss the Grievance. All requests for CenCal Health Grievance forms are to be mailed no later than the next business day from the date of the request.

4. All Standard and Expedited Grievances received either written or via the toll-free telephone number for the Member Services Department, are entered into and tracked on CenCal Health's on-line tracking system.

5. Members can file a Grievance at any time, and there is no limitation on the timeframe to file a Grievance with CenCal Health.

C. Member Services Grievance & Appeals Coordinator Research for Standard and Expedited Grievances; Verification of Coding

1. The G&A Coordinator reviews all Grievance documentation and research and:

   a. Assigns a code to categorize each Grievance; and

   b. Contacts the appropriate provider office(s) to validate date(s) of service and other information given by the Member.

2. The G&A Coordinator reviews each Grievance, including all information from the provider office(s) and any other pertinent research, and makes a recommendation as to whether or not there is a clinical component to the Grievance. The G&A Coordinator then refers the case to a Health Services Nurse within two (2) calendar days for verification of the accuracy of the G&A Coordinator's coding for clinical review necessity and confirmation of appropriate medical records, charts and other documentation that the G&A Coordinator will be obtaining for physician review.

3. Every Grievance is reviewed by a Health Services Nurse who is a Registered Nurse with an active license to practice nursing in California. The Health Services Nurse verifies the appropriateness of the G&A Coordinator's coding determination. This verification is based on clinical experience and application of clinical criteria. The Health Services Nurse notifies the G&A Coordinator of his/her decision and determines whether any additional information is required to process the Grievance. Additional information may or may not include medical records.

D. Non-Clinical Review Process

1. If the G&A Coordinator categorizes a Grievance as non-clinical, the Health Services Nurse reviews the Grievance documentation on CenCal Health's on-line tracking system and verifies that the Grievance has no clinical component within two (2) business days of receipt. If the Health Services Nurse determines that the Grievance may involve a clinical concern, the Nurse will notify the G&A Coordinator. The G&A 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 designated physician reviewer.
2. The Member Services Grievance & Appeals Quality Improvement Manager reviews and oversees all Grievance documentation and research. The Member Services Grievance & Appeals Quality Improvement Manager completes the non-clinical grievance review, documents findings, and follows-up with appropriate staff when necessary to address identified quality improvement opportunities regarding quality-of-service issues.

E. Clinical Review Process

1. When the G&A Coordinator determines that the Grievance requires clinical review, the G&A Coordinator completes the required documentation, including all pertinent information needed for the review by a physician reviewer, and a complete packet is presented to the Medical Management team/ licensed clinical professional nurse.
2. For Grievances that require a physician reviewer, the Medical Management team/ licensed clinical professional nurse reviews the completed packet and prepares a review summary for the Medical Management physician reviewer.
3. The physician reviewer must be different than the physician who reviewed the initial request or had any part in any prior decisions. The physician reviewer will also not be a subordinate of someone who participated in the initial review or decision.
4. The physician reviews the packet or consults with or directs the review, when necessary, to a practitioner in the same or similar specialty who typically treats the condition. The physician reviewer then directs appropriate departments to perform follow-up when necessary to address identified quality improvement opportunities.
5. All research of clinical issues that are part of the physician reviewer's findings are considered peer review protected via state statute.
6. The physician reviewer notifies the G&A Coordinator in writing of the completion of each clinical review for Grievances.
7. If the 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.

8. The Chairperson of the Peer Review Committee ensures that there is a reasonable effort made to obtain information regarding the matter, the case is evaluated thoroughly, there is adequate discussion among Committee members, and the case is finalized and signed off by the Chairperson of the Peer Review Committee.

F. Expedited Grievance Process

1. Upon receipt of an Expedited Grievance, the Member Services Grievance & Appeals –Quality Improvement Manager reviews Members' or providers' requests on behalf of the Member (with the Member's written consent) for Expedited Grievances immediately upon receipt and forwards to the Medical Management team/ licensed clinical professional Nurse and to the Chief Medical Officer or Medical Director for review to determine if the request meets DHCS criteria for Expedited Grievances.
    a. If the request meets criteria, in accordance with the DHCS guidelines, the Expedited Grievance is resolved, and an outcome is provided to the requestor within the 72-hour (3 calendar day) allowable review period.
    b. If it does not meet criteria, the Grievance then follows the standard 30-day Grievance process and the requestor is notified that the request did not meet expedited criteria verbally, followed by written notice of the downgrade from expedited to standard 30-day Grievance review. The acknowledgement letter sent to Member shall also advise the Member that he/she may file a Grievance against the downgrade.
2. For Expedited Grievances that require a physician reviewer, the Medical Management team/ licensed clinical professional nurse reviews the completed packet and prepares a review summary for the Medical Management physician reviewer.
3. The physician reviewer must be different than the physician who reviewed the initial request or had any part in any prior decisions. The physician reviewer will also not be a subordinate of someone who participated in the initial review or decision.
4. The physician reviews the packet and directs appropriate departments to perform follow-up when necessary to address identified quality improvement opportunities.
5. All research of clinical issues that are part of the physician reviewer's findings are considered peer review protected via state statute.

6. The G&A Coordinator calls the Member or appointed representative within the 72-hour time frame to advise of the outcome, and the final letter is mailed.

G. Exempt Grievances

1. Exempt Grievances must be resolved by the next business day.
2. Call inquiries that are received via CenCal Health's Call Center and classified as "Exempt Grievances" by the Member Services Representatives are reviewed by the Grievance & Appeals Quality Improvement Manager.
3. Exempt Grievances differ from general call inquiries due to a dissatisfaction component expressed by the Member; however, when offered a formal Grievance, the Member declines interest in filing a formal Grievance.
4. The Grievance & Appeals Quality Improvement Manager reviews Exempt Grievances on a daily basis to ensure accuracy of coding and overall process. Coding changes may occur, if necessary, as determined by the Grievance & Appeals Quality Improvement Manager. If it is determined that a standard Grievance is now required, the process above is followed for standard Grievance classification.

H. Discrimination Grievances

1. CenCal Health designates the position of "Compliance Investigator" within its Compliance Department as the Plan's "Discrimination Grievance Coordinator," who is responsible for ensuring compliance with federal and state non-discrimination requirements.
2. All Discrimination Grievances are immediately forwarded to CenCal Health's Compliance Investigator. The Compliance Investigator must investigate Grievances alleging any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination laws.
3. Discrimination Grievances are investigated separately from the Grievance process and not entered into CenCal Health's on-line Grievance tracking system and must follow the requirements for reporting discrimination Grievances to the Office of Civil Rights (OCR), as outlined by All Plan Letter (APL) 21-004.
4. CenCal Health's Discrimination Grievance procedures follow the applicable requirements outlined in APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates (superseding APL 17-006), including timely acknowledgment and resolution of Discrimination Grievances. Members are not required to file a Discrimination Grievance with CenCal Health before filing a Discrimination Grievance directly with DHCS OCR or the HHS OCR. More information on filing Grievances directly with OCR is made available to Members within CenCal Health's Evidence of Coverage/Member Handbook available for review/download on

CenCal Health's website, as well as the Notice of Non-Discrimination documents also posted on CenCal Health's website.

5. CenCal Health's Compliance Investigator is available to:
    a. Answer questions and provide appropriate assistance to CenCal Health staff and Members regarding CenCal Health's state and federal nondiscrimination obligations.
    b. Advise CenCal Health staff about non-discrimination best practices and accommodating persons with disabilities.
    c. Investigate and process any ADA, section 504, section 1557, and/or Government Code section 11135 grievances received by CenCal Health.

I. Mental/Behavioral Health Grievances

1. The G&A Coordinator summarizes and forwards documentation of all specialty mental/behavioral health clinical and non-clinical Grievances to Santa Barbara County Behavioral Wellness Department or MHS of San Luis Obispo (MHS-SLO) for specialty mental health services if the Grievance is pertaining to specialty mental health services. For all mild to moderate behavioral health Grievances, CenCal Health Grievance staff will initiate and investigate these Grievances and enter them into our on-line tracking system.
2. Within one (1) business day, the Santa Barbara County Behavioral Wellness Department or MHS - SLO QA Manager will acknowledge receipt of the complaint by secure e-mail to the G&A Coordinator. The QA Managers for Santa Barbara Behavioral Wellness or MHS-SLO researches and resolves Grievances directly with the Member.

J. Notification to Member of Disposition of Grievance

1. The G&A Coordinator acknowledges receipt of Members' Grievance, in writing, within five (5) calendar days. Members may submit additional comments, documents and other information relating to their Grievance. The acknowledgement letter is sent on Plan letterhead and contains the date the Grievance was received, a summary of the issue, a statement that their issue will be resolved within thirty (30) calendar days, the G&A Coordinator's name, phone number and the Plan address noted on the bottom of the official Plan letterhead.
2. The G&A Coordinator notifies Members, in writing, that CenCal Health has finished its review of their Grievance and provides a clear and concise explanation of the Plan's decisions, no later than thirty (30) calendar days from its receipt.
3. The Grievance Manager reviews all final letters prepared by the G&A Coordinators to ensure all aspects of the Grievance are addressed as applicable in the final documentation to the Member or their representative. This process of seeking the Member Services Grievance &

Appeals QI Manager's review and approval of final letter documentation occurs for the non-clinical and clinical review cases. For the clinical case final letters, only the findings unrelated to the Medical Director's findings can be shared. The Manager reviews to ensure the issues raised are addressed in a clear and concise manner in the final letter.

K. Mandated Language with Member Notification

1. For Knox-Keene Licensed programs (currently none under CenCal Health), Department of Managed Health Care (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, would be included on CenCal Health's website and in all of the following documents:
    a. CenCal Health's contracts with its providers;
    b. All Evidence of Coverage/Member Handbooks;
    c. CenCal Health's Member Grievance and Appeal System Policy and Procedure;
    d. Grievance and Appeal Forms,
    e. All written responses to Grievances and Appeals; and
    f. All written notices to Members required under the Grievance process of CenCal Health, including any written communications to Member that offer the Member the opportunity to participate in CenCal Health's Grievance process.
2. Pursuant to the Code of California Regulations Title 22 requirements, DHCS, and Code of Federal Regulations Title 42, mandated language must be included in all of the letters and/or Member notification listed above.
3. When sending the required Grievance notifications to Members, CenCal Health must comply with the nondiscrimination, language assistance requirements, and accessibility standards as outlined in APL 21-004 and APL 21-011, including translation, font, and format requirements, and any subsequent updates or revisions to the APL and attach the required documents to all Grievance notifications. The content of the notice must also comply with applicable state and federal law and all requirements of the contract between DHCS and CenCal Health.

IV. Definitions: See G&A Definition Addendum

V. References:

A. DHCS APL 22-012: Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx

B. DHCS APL 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services

C. DHCS APL 21-011: Grievance and Appeal Requirements, Notice, and "Your Rights" Templates

VI. Cross Reference:

A. Policy and Procedures (P&Ps):

1. HS-UM07 – Pre-Service Review
2. MS-23 – Member Appeals
3. MS-24 – Communication and Education of Grievance and Appeals Process
4. MS-25 – Monitoring and Oversight of Grievance and Appeals System

B. Standard Operating Procedures (SOPs):

1. MSSOP-062 – Intake of Grievance or Appeal by MSR
2. MSSOP-82 – Exempt Grievances
3. MSSOP-81 – Expedited Grievance Process
4. MSSOP-86 – Pharmacy Grievances & Appeals
5. MSSOP-80 – Standard Grievance Process

C. Program Documents:

1. Grievances & Appeals Definition Addendum
2. Provider Manual – Grievance & Appeals Section

VII. Attachments: N/A

Revision History:

P&P Revision Date	Leaders who Reviewed and Approved P&P Revisions	Reason for P&P Revisions	P&P Revision Effective Date (date P&P is operationalized)	DHCS P&P Approval Date
10/2023	Eric Buben, Director of Member Services	Checked-Out for 2024 Integration and moved to new P&P template.	10/2023	N/A
07/2023	Eric Buben, Director of Member Services	Restructuring of MS-20 resulted in a number of more specific P&Ps, including this one, which focuses on member grievances.	Upon DHCS Approval	12/2023

		Minimal, if any, changes to content.		