



Policy and Procedure No: RM 7.10		Revision No: 10
Division: Care Management		
Department: Risk Management		
Title: PHC-CA Enrollee Grievance Process		
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Reviewed/Revised by: Emelyne Beneche		Review/Revision Date: 6/4/2025
Approving Committee: Risk Management Committee		Date: 12/11/2025
Executive Oversight Committee Date: 12/16/2025		

Purpose:

To set forth Health Plan policies and procedures of PHC California (the Health Plan) for processing, monitoring, resolving, tracking and reporting enrollee grievances according to applicable law and the Health Plan’s contract with the California Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), Centers for Medicare & Medicaid Services (CMS) and other applicable regulatory bodies.

Policy:

It is the policy of the Health Plan to:

1. Allow enrollees, providers or authorized representatives with enrollee’s written consent to file a grievance with the Health Plan either orally or in writing.
2. Provide a notice of resolution to the enrollee as quickly as the enrollee’s health condition requires, not to exceed thirty (30) calendar days from the date the enrollee makes an oral or written request to the Health Plan for a grievance.
3. Notify enrollees of decisions of expedited grievances within seventy-two (72) hours. When written notification is required for expedited grievances, the Health Plan may initially provide verbal notification of its decision and deliver written confirmation of its decision within three (3) calendar days of the verbal notification.
4. Inform the enrollee of the disposition of their grievance and inform them of their right to file written complaints to the appropriate bodies.
5. Provide a notice of resolution in the enrollee’s preferred language.
6. Immediately submit grievances or appeals related to medical quality of care issues to the Health Plan’s medical director for action.
7. Ensure that the person making the decision on the grievance has clinical expertise in treating an enrollee’s condition or disease when deciding a request for expedited resolution of an appeal if a grievance is denied.
8. Ensure timely written acknowledgement of each grievance. Respond to all grievances in writing, or verbally by phone at the enrollee’s request. All responses are documented. If the enrollee has specifically requested a “no mail” status, email is offered as an alternative. If the

enrollee declines email, upload documents to the secure patient portal. If the enrollee is unable to access the portal, forward documents to the Primary Care Provider's (PCP's) office, in a separate and sealed envelope, that is addressed to the enrollee.

9. Ensure that enrollees are given a reasonable opportunity to present evidence and testimony, and make legal or factual arguments, in person, by telephone or in writing, in support of their grievance.
10. Provide its grievance policies and procedures to subcontractors at the time that they enter into a subcontractor agreement. In the event the Health Plan engages downstream contractors, the same policy applies.
11. Provide training to network providers and subcontractors on the Health Plan's grievance policies and procedures, and immediately notify network providers and subcontractors of any changes. In the event the Health Plan engages downstream contractors, the same policy applies.
12. Compile, aggregate and review grievance data as part of the Health Plan's ongoing monitoring procedures and for use in the Health Plan's Quality Improvement Strategy (QIS). The Health Plan regularly analyzes grievance data to identify, investigate, report, and act upon any systemic patterns of improper service denials and other trends impacting health care access and delivery to enrollees.
13. Maintain a record of each grievance which contains, at a minimum, all information set forth in 42 CFR 438.416(b):
 - a. A general description of the reason for the grievance.
 - b. The date received.
 - c. The date of each review or, if applicable, review meeting.
 - d. Resolution at each level of the appeal or grievance, if applicable.
 - e. Date of resolution at each level, if applicable.
 - f. Name of the covered person for whom the appeal or grievance was filed.
14. Pursuant to Sections 1351 (l) and 1352, and Rule 1300.51(d)(W), the Health Plan must file its policies and procedures, and form adopted by the Health Plan to comply with Section 1368 and rule 13000.68. In addition, the Plan must file written grievance procedures and forms the Plan makes available to enrollees and subscribers, including procedures for review of expedited grievances, Independent Medical Review and arbitration. See Appendix "A."

Procedure:

1. Maintaining Policies and Procedures regarding Grievances:
 - a. The Chief of Managed Care has the ultimate responsibility for the grievance system, which is monitored by the RN Clinical Risk Manager. The Chief is located at 1710

N. La Brea Ave., Los Angeles, CA 90046. The telephone number is 1-323-436-5000.

- b. The RN Clinical Risk Manager or designee, under the supervision of the Chief of Managed Care, is responsible for updating and maintaining the policies and procedures of the grievance system, as well as for continuously reviewing the operation of the grievance system to identify any emergent patterns of grievances.

2. Location of Files and Availability of and Assistance with Forms:

- a. The Chief of Managed Care is ultimately responsible for the grievance files. The RN Clinical Risk Manager or designee is responsible for the management, maintenance, and monitoring of the grievance files. Grievance files are stored in Salesforce, an integrated Customer Relationship Management (CRM) platform, which is maintained on a secure HIPAA-compliant cloud server in the U.S. Copies of the Health Plan's grievance forms are available at all PCP locations. When needed, an electronic version is available on the Health Plans website, Providers may also contact the Health Plan's Member Services (MS) Department for assistance. The form is available in Spanish and English.
- b. Member Services Representatives provide, upon request, a grievance form, either directly or by mail, if mailing is requested, to any enrollee requesting the form.
- c. The Health Plan makes a local or toll-free telephone service available to enrollees during normal business hours for requesting grievance forms, filing verbal grievances, and requesting information. The Health Plan's MS Department toll-free phone line (800-263-0067) is listed throughout the Membership Services Guide (Guide) and available at all primary care facilities.
- d. The Health Plan provides assistance to any enrollee who asks for help in completing the grievance form. Staff at any primary care site can assist an enrollee in completing the complaint/grievance form, which is located on the Health Plan's website. The Health Plan's MS Department or Health Plan staff are also available to assist enrollees, either by phone or in person.
- e. All Health Plan staff fulfill cultural and linguistic requirements and address any cultural or linguistic barriers that an enrollee may have in filing a grievance. Health Plan staff offer any assistance that may be required or requested. Language line services are available to all Health Plan staff to assist in oral interpretation, and staff also have access to written translation services.
- f. The Health Plan provides Auxiliary Aids, alternative formats and a toll-free number with TTY/TDD to assist enrollees with the filing of grievances.
- g. The Health Plan maintains records of grievances and appeals in a manner accessible to DHCS and CMS, upon request. The Health Plan retains all documents and records, whether in written or electronic format, of all grievances and appeals, the responses to them, and logs recording them for a period of at least ten (10) years from the date the grievance or appeal was filed. Documents include a copy of

all medical records, documents, evidence of coverage, and other relevant information upon which the Health Plan relied in reaching its decision.

3. Notifying Enrollees of the Grievance Process:

Enrollees are advised of the grievance procedure at the time of the enrollment presentation via the Membership Guide (“Evidence of Coverage”).

- a. The Guide is sent to each enrollee within seven (7) days of enrollment and annually thereafter.
- b. The Guide contains a description of the grievance process, including the following elements required by law:
 - i. An explanation of the Health Plan’s system for processing and resolving grievances, and how an enrollee is to use it.
 - ii. A statement that grievance forms are available in the office of each PCP, or in the Health Plan’s Member Services Department.
 - iii. A statement that grievances may be filed in writing or verbally directly with the Health Plan or at any office of the Health Plan’s providers.
 - iv. The local or toll-free telephone number an enrollee may call to obtain information, request grievance forms, and register a verbal grievance.
 - v. An explanation of the State's Medi-Cal Managed Care Ombudsman program and the program's voice and TDD telephone numbers.

4. Pursuant to the Contract, Contents of the Membership Services Guide:

- a. Procedures for filing a grievance with the Health Plan (orally and in writing), including procedures for appealing decisions regarding an enrollee’s coverage, benefits, or relationship to the Health Plan, or other dissatisfaction with the Health Plan and/or providers.
- b. Title, address, and telephone numbers of the Health Plan staff person responsible for processing and resolving grievances and responsible for providing assistance completing the request.
- c. Requirements and timelines for the Health Plan to acknowledge receipt of grievances and resolve grievances and notify the enrollee of the resolution of grievances or appeals.
- d. Information explaining how the enrollee may request continuation of services previously authorized by the Health Plan while the grievance is being resolved.
- e. Information on how to access State resources for investigation and resolution of enrollee complaints, including a description of the DHCS Medi-Cal Managed Care Ombudsman Program and toll-free telephone number (1-888-452-8609).



- f. A Statement of Understanding signed by the enrollee acknowledging their understanding of the enrollee grievance system. This form is part of the enrollment packet and enrollees sign this when they complete the enrollment forms. It is stored in the MS Dept. electronic enrollment forms or in paper for legacy enrollments. Additionally, enrollees are advised annually of the grievance procedure in their annual Guide and at the time of receipt of any notice of action.

5. Initiating a Grievance:

- a. An enrollee, their provider, or authorized representative with the enrollee's written consent may file a grievance orally or in writing at any time following any incident or action that is the subject of their dissatisfaction. The Health Plan does not discourage the filing of grievances. An enrollee need not use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance.
 - i. If an enrollee expressly declines to file a grievance, the complaint is categorized as a grievance and not an inquiry. While the Health Plan may protect the identity of the enrollee, the complaint is still aggregated for tracking and trending purposes as with other grievances.
 - ii. If an enrollee expresses quality of care (QOC) concerns in a declined grievance, the Health Plan investigates without providing further information to the enrollee. The Grievances and Appeals Team initiates a Potential Quality Issue (PQI) depending on the nature of the grievance or recurring issues.
 - iii. In the PQI or PQOC process (defined in Policy and Procedure RM 3 PHC-CA Potential Quality Issues), the RN Clinical Risk Manager and the Medical Director collaborate to investigate internally, but the Health Plan is not obligated to inform the enrollee. The Health Plan initiates a Corrective Action Plan (CAP) based on the investigation's outcome.
- b. An enrollee or authorized representative may file their grievance orally by calling Member Services at 1-800-263-0067.
 - i. Member Services verifies whether a copy of the Appointment of Authorized Representative (AAR) form, living will, or durable medical power of attorney is in the system and valid.
 - a) If a form is on file and valid, the MS Rep proceeds with documenting the grievance.
 - b) If a form is not on file or not valid, the MS Rep requests to speak with the enrollee.
 - i. If the enrollee is available, the MS Rep verifies HIPAA and obtains verbal consent to file a grievance. The MS Rep informs the enrollee and the caller that a signed consent form is required in order to provide additional information to the



caller after the grievance is filed. If consent is not received, all future communication related to the grievance is addressed to the enrollee.

- ii. If the enrollee is not available, the MS Rep advises the caller of the process and where the form is available.
- c) If the grievance is submitted in writing or via voicemail, the grievance is not processed until a valid form is received.
- c. An enrollee or authorized representative may submit a written grievance twenty-four (24) hours a day, seven (7) days a week (including holidays) using the following methods:
 - i. Via email at PHP@positivehealthcare.org;
 - ii. Via the electronic Grievance Submission Form located at: <https://positivehealthcare.net/florida/php/for-members/complaint/>;
 - iii. Via Fax at 1-888-235-8552;
 - iv. Via U.S. mail at:

PHC California
1710 N. La Brea Ave.
Los Angeles, CA 90046
Attn: Member Services Department

- d. Enrollees include the date of submission, enrollee name, enrollee ID, nature of the grievance, persons involved, and any additional details related to the grievance. The enrollee may also submit the grievance form via email, fax, or U.S. mail. Health Plan staff can assist with the completion of the form upon request.
 - i. The Health Plan staff, who initially encounters the enrollee reporting the grievance, has the primary responsibility to address the concern and attempt to resolve the issue promptly.
 - ii. For oral submissions, Health Plan staff and/or the MS Department documents the grievance using the online Grievance Submission Form and notifies the Grievance and Appeal Team directly of the grievance via email on the same day. All grievances received by telephone are documented objectively, from the enrollee's perspective, by the Health Plan staff who initially encounter the enrollee.
 - iii. For written grievances that are submitted to Health Plan staff outside of Member Services, staff date stamps the grievance on the day it was received and forward it to the MS Department via fax or email on the same day.
- e. ON NO ACCOUNT MAY AN ENROLLEE BE DISCRIMINATED AGAINST ON THE GROUND THAT THE ENROLLEE HAS FILED A GRIEVANCE.



- i. All primary care facility staff (including medical providers, administrative staff, etc.) are notified during training arranged by the Member Services/Enrollment leadership team and reminded that enrollees filing complaints or with intentions to disenroll may not be discriminated against. A filed grievance/complaint or intent to file a grievance/complaint does not impede clinical and medical care provided to the complainant as an enrollee of the Health Plan.

6. Logging Grievances:

- a. The Member Services Department or any Health Plan staff can document grievances received by the Health Plan in the MS Module or via the new online Grievance Submission form located at <https://ahfforms.formstack.com/forms/grievanceform>.
- b. After documenting the complaint, the MS representative notifies the Grievance and Appeal Team of the complaint by sending an email to QIGrievancesCAFL@aidshhealth.org for triage.
- c. The Grievance and Appeal Team triage and review the case details to confirm if the issue is resolved or needs further investigation.
- d. In the event of insufficient information, the Grievance and Appeal Team and Member Services make reasonable efforts to obtain the missing information in order to resolve the grievance within the specified timeframe.

7. Documenting / Tracking Grievances:

A written record is maintained for each grievance. The record of each grievance must contain, at a minimum, all information set forth in 42 CFR 438.416(b). Grievance documentation captures all the elements required to be reported in accordance with state and federal reporting requirements (e.g. DHCS, DMHC, CMS). These elements include:

- a. The date and time of receipt of the grievance
- b. The name of the enrollee filing the grievance
- c. The representative recording the grievance
- d. A description of the complaint or problem
- e. A description of the action taken by the Health Plan or provider to investigate and resolve the grievance
- f. The proposed resolution by the Health Plan or provider
- g. The name of the Health Plan provider or staff responsible for resolving the grievance

- h. The date of notification to the enrollee of resolution
- i. Complaint examples:
 - i. Waiting time for appointments
 - ii. Untimely assignments to a provider
 - iii. Issues related to cultural and linguistic sensitivity
 - iv. Difficulty accessing specialists
 - v. Administration and delivery of medical services and benefits
 - vi. Coverage disputes
 - vii. Disputes involving medical necessity
 - viii. Quality of care
 - ix. Access to care (including complaints about the waiting time for appointments)
 - x. Quality of service
 - xi. Other issues
- j. Enrollee geographic region
- k. Enrollee ethnicity
- l. Enrollee gender
- m. Primary language of enrollee
- n. Status of the grievance: received, resolved, or pending
- o. Whether the grievance was resolved in favor of the enrollee or the Health Plan
- p. The number of grievances pending over thirty (30) calendar days. The logs also indicate whether an enrollee's grievance is pending at:
 - i. The Health Plan's internal grievance system;
 - ii. The Department's consumer complaint process;
 - iii. The Department's Independent Medical Review system;
 - iv. An action filed or before a trial or appellate court; or
 - v. Other dispute resolution process.

8. Acknowledging the Grievance:

- a. The Grievance Coordinator provides a written acknowledgment that is dated and postmarked within five (5) calendar days of receipt of a grievance.
- b. The acknowledgment advises the enrollee that the grievance has been received, the date of receipt, and provides the name of the Health Plan representative, telephone number, and address of the Health Plan representative who may be contacted about the grievance.
- c. The Department's telephone number, the California Relay Service's telephone numbers, the Health Plan's telephone number, and the Department's internet address are displayed in all Health Plan acknowledgments and responses to grievances in at least twelve (12) point boldface type with the statement contained in the Knox-Keene Act:

“The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-263-0067** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.”

9. Grievance Resolution:

- a. General Timelines for Responding to Grievances
 - i. When appropriate, the Health Plan strives to resolve grievances/complaints immediately or within a turnaround time of twenty-four (24) hours.
 - ii. However, enrollee grievances are resolved within thirty (30) days of the enrollee's submission of a written grievance or, if the grievance is made verbally, it is resolved within thirty (30) days of the written record of the grievance.

- iii. An enrollee may withdraw a grievance at any time prior to resolution. If the enrollee withdraws a QOC grievance, the Health Plan continues investigating without providing further information to the enrollee. The Grievance and Appeal Team initiates a Potential Quality Issue (PQI) depending on the nature of the grievance or repeating issues. Issues are trended and tracked for potential trend.
- b. The Health Plan's Grievance and Appeal Team analyze all logged comments, documents, records and other information submitted by the enrollee, their provider or authorized representative. The Grievance Coordinator collaborates with the appropriate departmental manager or delegated vendor/provider/facility for prompt review and resolution of the grievance.
- c. The Grievance Coordinator is responsible for ensuring that the person making the final decision for the proposed resolution of a grievance has neither participated in any prior decisions related to the grievance, nor is a subordinate of someone who has participated in the prior decision. Any grievances related to medical quality of care issues are immediately submitted to the Health Plan's Medical Director for action.
- d. When a grievance regards denial of a request for expedited resolution of an appeal (or other issue involving clinical care), the Health Plan's Medical Director is responsible for ensuring a person with clinical expertise in treating an enrollee's condition or disease is involved in the review/resolution.
- e. Management or supervisory staff responsible for the services or operations that are the subject of the grievance, promptly review the grievances.
- f. The Grievance and Appeals team reports all grievances not resolved in a timely manner as "pending" (DMHC) or "unresolved" (DHCS) grievances.
- g. The Grievance and Appeal Team mails a written response of resolution to grievances within thirty (30) calendar days of receipt in the enrollee's preferred language. Even though federal regulations allow for an extension of fourteen (14) calendar days for standard and expedited appeals, this allowance does not apply to grievances. In the event that resolution of a standard grievance is not reached within thirty (30) calendar days as required, the Health Plan notifies the enrollee in writing of the status of the grievance and the estimated date of resolution.
- h. The written resolution contains a clear and concise explanation of the Health Plan's decision. The Health Plan does not disclose information to the grievant that is confidential or privileged by law, such as disciplinary action toward employees of the Health Plan or the Health Plan's providers.
- i. In the case of an enrollee with visual impairments or other disabilities, the provision of written materials in alternative formats, that are in compliance with the Americans with Disabilities Act (ADA), is required.
- j. The written resolution includes language assistance taglines and a nondiscrimination notice meeting the minimum requirements of DHCS APL 21-004.

The nondiscrimination notice is made available, upon request or as otherwise required by law, in all of the Threshold Languages/Threshold or Concentration Standard Languages.

- k. For expedited grievances, the enrollee, provider or authorized representative is notified orally within seventy-two (72) of the resolution, followed by written notification.

10. Exempt Grievances:

Grievances received over the telephone that are not coverage disputes, disputed healthcare services involving medical necessity, or experimental or investigational treatment, and that are resolved by the close of the next business day, are considered exempt from the DHCS/DMHC requirement to send a written acknowledgment and response.

- a. However, the Grievance and Appeal Team sends a notification letter, informing the enrollee that the issue was logged for tracking/trending within ten (10) days of the receipt date.
- b. The Health Plan maintains a log of all such grievances containing the date of the call, the name of the complainant, enrollee ID number, nature of the grievance, nature of the resolution, and the representative's name who took the call and resolved the grievance.
- c. The information is contained in the log periodically reviewed by the Health Plan Executive Oversight Committee. The Grievance and Appeal Team ensures exempt grievances are incorporated into the required Grievance and Appeal Report that is submitted to DHCS.

11. Discrimination Grievances:

DHCS does not unlawfully discriminate on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or any other basis protected by federal or State civil rights laws. For grievances filed by enrollees, or potential enrollees that allege discrimination, the Health Plan complies with the following process:

- a. Designation and Responsibilities

The Discrimination Grievance Coordinator or designee is responsible for ensuring compliance with federal and State nondiscrimination requirements and investigating discrimination grievances related to any action that would be prohibited by, or out of compliance with, federal or State nondiscrimination law. The Discrimination Grievance Coordinator or designee also:

- i. Answers questions and provides appropriate assistance to Health Plan staff and members regarding the Plan's state and federal nondiscrimination obligations;

- ii. Advises the Health Plan on nondiscrimination best practices and providing accommodations to persons with disabilities;
- iii. Investigates and processes all grievances related to the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, Section 1557 of the Affordable Care Act, and California Government Code Section 11135.b. Grievance Procedures

The Health Plan adopts procedures to ensure the prompt and equitable resolution of discrimination grievances by the Health Plan. The Health Plan does not require an enrollee or potential enrollee to file a discrimination grievance with the Health Plan before filing with the DHCS Office of Civil Rights (OCR) or the U.S. Health and Human Services Office for Civil Rights. The Health Plan informs enrollees on its website that discrimination grievances may be filed directly with the DHCS Office of Civil Rights and includes contact information for this office.

The Health Plan's discrimination grievance procedures follow the requirements outlined in sections III (A) – (C) of APL 21-011, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments, or any superseding APL, including timely acknowledgement and resolution of discrimination grievances.

c. Prohibition on Peer Review Use

The Health Plan does not use a medical peer review body to investigate or resolve discrimination grievances. The Health Plan does not claim confidentiality for discrimination grievance investigations or resolutions under Evidence Code Section 1157 or Business and Professions Code Section 805. However, the Health Plan may refer a grievance to a peer review body if quality-of-care concerns are involved.

d. Submission to DHCS OCR

The Grievance and Appeal Team forwards all member discrimination grievances regardless of outcome to DHCS OCR when they involve any characteristic protected under federal or State nondiscrimination laws. This includes language access complaints and complaints involving failure to provide reasonable accommodation under the ADA. This includes, without limitation, sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, creed, health status, or identification with any other persons or groups defined in Penal Code section 422.56.

Within ten (10) calendar days of mailing a discrimination grievance resolution letter to an enrollee, the RN Clinical Risk Manager or designee reviews and submits detailed information regarding the grievance to DHCS OCR's designated discrimination grievance email. The RN Clinical Risk Manager or designee submits information listed below to DHCS at



DHCS.DiscriminationGrievances@dhcs.ca.gov in a secure email format, and copies the Health Plan Administrator and the Compliance Officer on the email:

- i. The original discrimination grievance
- ii. The provider's or other accused party's response to the discrimination grievance
- iii. Contact information for the personnel primarily responsible for investigating and responding to the discrimination grievance on behalf of the Health Plan
- iv. Contact information for the person filing the discrimination grievance, and for the provider or other accused party that is the subject of the discrimination grievance
- v. All correspondence with the person filing the discrimination grievance regarding the discrimination grievance, including, but not limited to, the discrimination grievance acknowledgment letter and resolution letter
- vi. The results of the Health Plan's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination
- vii. The RN Clinical Risk Manager or designee uploads all discrimination grievance documentation, including the email sent to DHCS and their acknowledgment, to the enrollee's grievance file in Salesforce.

e. Annual Attestation

The Health Plan submits an annual attestation each December via the Managed Care Operations Division (MCO) SharePoint Submission Portal, confirming that all required discrimination grievance information is submitted to DHCS OCR in compliance with applicable regulations.

f. Record Retention

The Health Plan retains all records related to discrimination grievances for at least three (3) calendar years from the date of resolution, as required by 45 CFR § 92.8(c)(2). These records include:

- i. The grievance description;
- ii. The complainant's name and contact information, if provided;
- iii. The alleged discriminatory action and basis for the complaint;
- iv. Dates of grievance filing and resolution;
- v. The final resolution and outcome, and all other supporting documents.

12. Health Insurance Portability and Accountability Act (HIPAA) Related Grievances:

The Compliance Officer or their delegate is actively involved in the investigation and resolution of grievances related to confidentiality and/or HIPAA violations.

- a. The Grievance and Appeal Team notifies the Compliance Officer immediately of any grievance concerning privacy/enrollee confidentiality.
- b. Upon conclusion of the investigation, the Grievance and Appeal Team communicates all findings to the Compliance Officer for guidance.
- c. The Compliance Officer evaluates these concerns and takes appropriate action.

13. Expedited Grievances:

If the grievance involves an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function, that do not involve the appeal of an Adverse Benefit Determination, it is considered an "urgent" or "expedited" grievance, and the following apply:

- a. Member Services and/or the Grievance and Appeal Team immediately notifies the enrollee of the right to contact DHCS/DMHC regarding the grievance. The Health Plan expedites its review of the grievance when the complainant, an authorized representative, or treating physician provides notice to the Health Plan. The notice need not be in writing; it may be accomplished by a documented telephone call.
- b. Within twenty-four (24) hours of receiving the grievance, the Health Plan notifies the enrollee whether or not the grievance met the criteria for expedited review, as defined by policy.
 - i. If criteria are met, the Grievance and Appeal Team informs the enrollee of the shortened timeframe to submit information related to their case and of their right to notify DHCS of their grievance.
 - ii. If criteria are not met, the Grievance and Appeal Team informs the enrollee, by mail within three (3) calendar days of receiving the grievance, and advises that the complaint is to be processed as a standard grievance.
- c. The Health Plan provides a written statement to DHCS/DMHC and the complainant on the disposition or pending status within seventy-two (72) hours of receipt of an expedited grievance. It is recorded by the date and time it was received.
- d. The Health Plan makes reasonable efforts to provide oral notice to the enrollee of the resolution.
- e. The Health Plan and Grievance and Appeal Team consider the enrollee's medical condition when determining the response time.

- f. The enrollee need not participate in the Health Plan's grievance process prior to applying to DHCS/DMHC for review of the urgent grievance.
- g. DHCS/DMHC is able to contact the Health Plan regarding grievances twenty-four (24) hours a day, seven (7) days a week, as follows:
 - i. A representative of the Health Plan with authority to resolve the grievance for the enrollee is available twenty-four (24) hours a day, seven (7) days a week by contacting the Health Plan's After-Hours Urgent Care Hotline at 1-800-797-1717 during non-work hours or through the MS Department at 1-800-263-0067 during work hours.
 - ii. Back-up Health Plan representatives are available during all hours.
 - iii. Health Plan representatives who are available include at least two (2) of the following: the RN Clinical Risk Manager, the Chief of Managed Care, and the Managed Care Medical Director.
 - iv. During normal work hours, the representative responds to DHCS/DMHC within thirty (30) minutes after initial contact from DHCS/DMHC.
 - v. During non-work hours, the representative responds to DHCS/DMHC within one (1) hour of initial contact from DHCS/DMHC.
- h. The Health Plan provides verbal notice of the resolution of an expedited review.

14. Medi-Cal Rx Complaints and Grievances:

As of January 1, 2022, Medi-Cal Rx is responsible for managing the resolution of complaints and grievances raised by Health Plan enrollees, their authorized representatives, or other interested parties, regarding a Medi-Cal Rx complaint or grievance.

Medi-Cal Rx complaints and grievances may be filed at any time, and are not subject to any specific codified timeframes, relative to the incident or action that is the subject of the complainant's dissatisfaction. Complaints or grievances may be made orally or in writing, consistent with all applicable State and federal law requirements and DHCS policies and procedures.

DHCS oversees the Medi-Cal Rx complaint and grievance process to ensure appropriate and timely handling and resolution occur.

The following outlines Medi-Cal Rx complaint and grievance processing requirements, which are intended to help manage transitional responsibilities for pharmacy-related complaints and grievances:

- a. Pharmacy-related complaints and grievances received on or after January 1, 2022, by the Medi-Cal Rx Customer Service Center (CSC) for services provided by the Health Plan on or before December 31, 2021, are transferred by the Medi-Cal Rx CSC to the Health Plan for full resolution.



- i. The Medi-Cal Rx CSC advises Health Plan enrollees to contact the Health Plan for such pharmacy-related complaints and grievances. Complaints and grievances received via phone or secure chat are appropriately triaged and referred by the Medi-Cal Rx CSC to the Health Plan via phone once they are determined to be a complaint or grievance.
 - ii. The Medi-Cal Rx makes its best efforts to immediately forward complaints and grievances for timely and accurate resolution by the Health Plan. Complaints and grievances received in writing are appropriately triaged and mailed or faxed within three (3) calendar days.
- b. Pharmacy-related complaints and grievances, received by the Health Plan for Medi-Cal Rx services provided on or after January 1, 2022, are transferred by the Health Plan to the Medi-Cal Rx CSC for resolution.
 - i. Complaints and grievances coming in via phone or secure chat must be appropriately triaged and referred to the Medi-Cal Rx CSC via phone once they are determined to be a Health Plan enrollee complaint or grievance.
 - ii. The Health Plan makes its best efforts to immediately forward complaints and grievances for timely and accurate resolution by the Medi-Cal Rx CSC. Complaints and grievances received in writing are appropriately triaged and mailed or faxed to the Medi-Cal Rx CSC within three (3) calendar days.

15. Trans-inclusive Health Care Complaints and Grievances:

If the grievance involves issue related to trans-inclusive health care, the following apply:

- a. As described in above, a Health Plan representative advises enrollees of their right to submit grievances to the Health Plan and DMHC at the time of enrollment via the Membership Guide (“Evidence of Coverage”). In addition, the Health Plan’s website advises enrollees of their right to submit grievances specific to failure to provide trans-inclusive care.
- b. As described in Procedure #7 above, the Grievance Coordinator maintains a written record for each grievance, including those submitted against the Health Plan, its subcontractors, downstream contractors, or staff for failure to provide trans-inclusive care.
- c. As described in item #1 of the Monitoring section to follow, the Health Plan complies with grievance reporting requirements set forth in its DHCS Contract. The Grievance Coordinator and the Associate Director of EDI and Data Analytics or designee(s) report all enrollee grievances submitted against the Health Plan or its subcontractors, downstream contractors or staff for failure to provide trans-inclusive health care through the monthly Managed Care Program Data (MCPD) file under the “Gender Affirming Care Type.”
- d. The Grievance Coordinator or designee is responsible for pulling the detail related to the grievance data reported through the Health Plan’s monthly MCPD file under the “Gender Affirming Care” benefit type when an outcome of the grievance reported is



resolved in the enrollee's favor.

- i. The Grievance Coordinator or designee pulls information described above within five (5) working days of a resolution of grievance in the member's favor, regardless of whether the data has already been submitted to DHCS in the Health Plan's MCPD file.
- ii. The Grievance Coordinator or designee informs the affected individual, their immediate supervisor, and the Learning and Development Department that the individual must retake TGI cultural competency training within forty-five (45) days of the grievance's resolution and before the individual has direct contact with enrollees again. The Grievance Coordinator or designee tracks and monitors any individuals required to retake the TGI training.
- iii. The Grievance Coordinator collects, tracks and reports all data elements related to verification reporting of required retaking of TGI training, including: grievance date, Health Plan reference number, name of the individual(s), position title, affiliation with the Health Plan, and completion date of TGI refresher training.
 1. The Grievance Coordinator or designee supplies the information above to the Compliance Officer for reporting purposes. The Compliance Officer or designee submits verification of completed refresher trainings to DHCS no later than thirty (30) calendar days following the monthly MCPD submission that reports resolution of any grievances in the enrollee's favor.
 2. To prevent future complaints, the Grievance Coordinator or designee supplies the information above to the Risk Management Committee, QIHEC, and EOC for further discussion and action, if necessary.
- iv. On a quarterly basis, the Grievance Coordinator or designee prepares a written report of grievances for review by appropriate committees. The report analyzes grievances resolved in favor of enrollees and identifies patterns of repeated grievances against an individual, or multiple grievances against multiple individuals of the Health Plan, its subcontractors, or downstream subcontractors. The report assesses whether these patterns give rise to a presumption that the Health Plan, its subcontractors, or downstream subcontractors are not providing adequate trans-inclusive care as required.
 1. In the event such a presumption arises, the Health Equity Officer, working in conjunction with the Compliance Officer, prepares a correction action plan (CAP) to address any deficiencies. The Compliance Officer monitors individual and organizational compliance with the CAP.

16. Section 1371.34 – Grievances About Delay or Denial of Payment of a Claim

- a. The Health Plan treats all member complaints, concerns, or expressions of dissatisfaction about delays or denials of claim payments as grievances.
- b. To align with the statutory requirement added under Section 1371.34 of the Knox-Keene Act, effective January 1, 2026, the Health Plan will actively classify and process any complaint, concern, or expression of dissatisfaction from an enrollee about the delay or denial of a claim payment as a grievance, as required by Section 1371.34 of the Knox-Keene Act. Staff will treat these issues as grievances even if the member does not use the word “grievance.”
- c. The Health Plan will follow the grievance handling procedures outlined in Section 1368 and Title 28, California Code of Regulations, Section 1300.68, to ensure full regulatory compliance and consistent, timely resolution for members.

17. Grievance Categories (Quality of Service versus Quality of Care):

All grievance categories are validated by the RN Clinical Risk Manager and Health Plan Medical Director. All grievances related to medical quality of care issues are immediately submitted to the Health Plan’s Medical Director for action.

18. Final Decision:

The person making the final decision for the proposed resolution of a grievance cannot be a person who has participated in any prior decision related to the grievance.

19. Enrollee’s Reasonable Opportunity to Present:

The enrollee has a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the grievance, evidence, facts, and law in support of their grievance. In the case of an expedited review (see below), the Health Plan informs the enrollee of the limited time available to present evidence. The Health Plan complies with an enrollee’s request to review records in connection with a grievance.

20. Grievance and Appeal System Oversight:

The Health Plan establishes, implements, and maintains a Grievance and Appeal System to ensure the receipt, review, and resolution of grievances and appeals. The Grievance and Appeal System operates in accordance with all applicable federal regulations, state laws, and state regulations.

21. Reporting of Pending or Unresolved Grievances:

The Health Plan submits a report to DHCS and a report to DMHC, as required, in a timely manner describing grievances that were or are pending and unresolved. Any reports required monthly are prepared and submitted by the tenth (10th) day of each month. Any reports required quarterly are prepared for the periods ending March 31st, June 30th, September 30th, and December 31st of each calendar year and submitted in accordance with DMHC requirements. The Health Plan uses the prescribed format in DHCS policy letters and All Plan Letters (APLs).



Definitions:

1. Inquiry: An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other Health Plan processes.
2. Grievance:
 - a. DHCS: Per DHCS APL 21-011, a grievance is any expression of dissatisfaction about any matter other than an adverse benefit determination (defined in Policy and Procedure UM 24.4). Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the enrollee's right to dispute an extension of time proposed by the Health Plan to make an authorization decision.
 - b. DMHC: Pursuant to 28 CCR 1300.68(a)(1), "Grievance" means a written or oral expression of dissatisfaction regarding the Health Plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the Health Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.
3. Complaint: A complaint is the same as a grievance (28 CCR 1300.68(a)(2)). If the Health Plan is unable to distinguish between a grievance and an inquiry, it must be considered a grievance.
4. Complainant: Complainant is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee (28 CCR 1300.68(a)(3)).
5. Quality of Care (QOC) Grievance: A grievance related to whether the quality of covered services provided by the Health Plan or provider meets professionally recognized standards of health care, including whether appropriate healthcare services have been provided or have been provided in appropriate settings.
6. Exempt Grievances: Grievances that are not coverage disputes, disputed healthcare services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt.
7. Expedited / Urgent Grievance: Grievances involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function.
8. Discrimination Grievance: A grievance that alleges discrimination on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or any other basis protected by federal or State civil rights laws.
9. Resolved: "Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority (28 CCR 1300.68(a)(4)).

- a. If the plan has multiple internal levels of grievance resolution or appeal, all levels must be completed within thirty (30) calendar days of the plan's receipt of the grievance.
- b. Grievances that are not resolved within thirty (30) calendar days, or grievances referred to the Department's complaint or independent medical review system, shall be reported as "pending" grievances pursuant to subsection (f) below. Grievances referred to external review processes, such as reviews of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, or the Medi-Cal Fair Hearing process, shall also be reported pursuant to subsection (f) until the review and any required action by the plan resulting from the review is completed.

10. TGI: means transgender, gender diverse or intersex.

11. Trans-inclusive health care: means comprehensive health care that is consistent with the standards of care for individuals who identify as TGI, honors an individual's personal bodily autonomy, does not make assumptions about an individual's gender, accepts gender fluidity and nontraditional gender presentation, and treats everyone with compassion, understanding, and respect.

Monitoring:

- 1. The Health Plan complies with reporting requirements set forth in Exhibit A, Attachment 3, Management Information System, of the DHCS Contract for reporting all grievance and appeal data. Required reporting of grievance data described above is reviewed in the aggregate to determine opportunities for quality improvement. The Risk Management Program Manager makes recommendations to the appropriate Committees as needed to address the findings.
- 2. The Grievances Dashboard provides periodic Health Plan trends and comparisons, by unique enrollees and by the number of issues reported, to analyze rates against the organizational threshold.
- 3. Grievance data are submitted at least quarterly to the Health Plan's Risk Management and Quality Management Committees for review and appropriate action. Grievances include, but are not limited to, those related to access to care, quality of care, and denial of services. The Committees take appropriate action to remedy any problems identified in their reviews.
- 4. Grievances related to alleged HIPAA violations are reported to the Compliance Department regularly.
- 5. The written record of grievances and appeals must be reviewed periodically by the Executive Oversight Committee of the Board of Directions (EOC), the Public Policy and Community Advisory Committee (PPCAC), and by an officer of the Plan or their designee.
- 7. DHCS and DHMC Grievance Reports are prepared and submitted in accordance with content and timing requirements.
- 8. This policy is updated, as necessary, and reviewed and approved at least annually by the Risk Management Program Manager.



Reference(s):

1. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011, Grievances and Appeal Requirements, Notice and “Your Rights” Templates
2. Department of Health Care Services (DHCS) All Plan Letter (APL) 25-005, Standards For Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services.Supersedes All Plan Letter 21-004
3. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-035, Medi-Cal Pharmacy Benefit Carve Out - Medi-Cal Rx
4. 22 CCR 53858 and 28 CCR 1300.68
5. CFR 438.228, 438.3, 438.400-424, 438.606,45 CFR section 92.8(c)(2),
6. Number 11-W-00193/9 (CalAIM) Special Terms and Conditions (STCs), Section V.A.19.f
7. Department of Managed Health Care (DMHC) APL 24-018 – Compliance with Senate Bill 923
8. California Code, Health and Safety Code - HSC § 1367.043
9. Department of Health Care Services (DHCS) All Plan Letter APL 25-007 (OFR) – Assembly Bill 3275 Guidance (Claim Reimbursement)

Regulatory Agency Approval(s):

Date	Version	Agency/Purpose	Purpose	Response
11/7/2023	7.4	Department of Health Care Services (DHCS)	2024 Operational Readiness (OR) Item R.0147	AIR 1
11/7/2023	7.4	DHCS	OR R.0149	AIR 1
11/8/2023	7.4	DHCS	OR R.0150	AIR 1
12/5/2023	7.4	DHCS	OR R.0148.1	Approved
12/5/2023	7.5	DHCS	OR R.0150 AIR 1	Approved
12/7/2023	7.5	DHCS	OR R.0149 AIR 1	AIR 2
12/15/2023	7.5	DHCS	OR R.0156	Approved
Not avail.	7.5	DHCS	OR R.0220	Approved
12/21/2023	7.5	DHCS	OR R.0147 AIR 1	Approved
12/21/2023	7.6	DHCS	OR R.0149 AIR 2	Approved
4/9/2025	7.7	Department of Managed Health Care (DMHC)	Filing No. 20251102	Comment Table
6/4/2025	7.8	DHCS	APL 25-005	AIR1
6/20/2025	7.9	DHCS	APL 25-005 AIR 1	Approved
7/8/2025	7.9	DMHC	Filing No. 20251102-1	Filing Closed
TBD	7.10	DMHC	Filing No. 20253578	Pending



APPENDIX A



CHECKLIST FOR HEALTH CARE SERVICE PLAN GRIEVANCE SYSTEM

This checklist is not intended to be all-inclusive; it only represents what issues, at a minimum, the Health Care Service Plan (Plan) must address when proposing a new or amended Grievance System Document. The Department of Managed Health Care (Department) may request additional information as necessary during its review to make a finding under the Knox-Keene Health Care Service Plan Act of 1975, as amended.¹

Background:

Pursuant to Sections 1351(l) and 1352, and Rule 1300.51(d)(W), the Plan must file for review its policies, procedures, and forms adopted by the Plan to comply with Section 1368 and Rule 1300.68. In addition, the Plan must file written grievance procedures and forms the Plan makes available to enrollees and subscribers, including procedures for the review of expedited grievances, Independent Medical Review and Arbitration. See Rule 1300.67.3(a)(3).

General Filing Information:

- File all grievance system documents as either a Notice of Material Modification or Amendment Filing:
 - Notice of Material Modification: Submit a Notice of Material Modification (Notice) when the Plan's proposed change or addition to the grievance system has a material effect on the Plan's operations in accordance with Rule 1300.52.4(d).
 - **TIMING:** The Plan should submit a Notice **as early as possible, and prior to the document going into effect**. Grievance system documents filed in a Notice may not go into effect until granted approval by the Department. See Rule 1300.52.4(d).
 - Amendment Filing: Submit an Amendment Filing when the grievance system does not have a material effect on the Plan's operations in accordance with Section 1352, and Rules 1300.52 and 1300.52.4(a) or (b). The Plan must file all changes to information previously provided to and reviewed by the Department, including new and revised grievance system policies, procedures or template communications.
 - **TIMING:** If possible, submit Amendment Filing prior to the document(s) going into effect. Amendment Filings must be submitted within 30 days of going into effect. See Rule 1300.52.4(b)(i)(A).
- Revised Exhibits: If the Plan has revised documents previously approved by the Department, file the revised document as the proper Exhibit type, and identify in

¹ California Health and Safety Code Sections 1340 et seq. (Act). References herein to "Section" are to Sections of the Health and Safety Code. References to "Rule" refer to the regulations promulgated by the Department, the California Code of Regulations, title 28.

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Exhibit E-1 the eFile number affiliated with the previously approved document. Changes to the approved document must be identified via highlight or strikeout, in accordance with Rule 1300.52(d). Also submit a clean copy of the revised Exhibit in the filing.

- Improperly Filed Documents:** The Department will not review improperly filed Notices, Amendments, and Exhibits. The Plan will be required to re-file and/or withdraw improperly filed Notices, Amendments, and Exhibits prior to review by the Department.
- Duration of Department Review:** The duration of the Department's review will vary on a case by case basis. Duration of review depends on the quality of the documents and information provided by the Plan, and the complexity of the filing.

MINIMUM REQUIRED INFORMATION: GRIEVANCE SYSTEM FILING

Exhibit E-1: eFiling Narrative

To allow the Department to conduct an effective review, the Plan must provide a summary description of the filing, covering the highlights and essential features of the information and documents provided by the Plan in the filing. See Rule 1300.51(d)(E)(1). The Plan must also provide all information necessary for the Department to make a finding under the Act that the proposed Amendment or Notice is in the public interest and consistent with the intent and purposes of the Act. See Rule 1300.52.4(a)(ii). Therefore, in the Exhibit E-1 provide a detailed narrative description of the filing including a response to each item below:

1. Purpose of Filing: Describe the purpose of the filing.

- Examples:

- The purpose of this filing is to update the address on the Plan's Grievance Form.
- The purpose of this filing is to respond to Survey/Exam No. 2018xxxx.
- The purpose of this filing is to respond to a Corrective Action Plan (CAP), dated xx/xx/xx, filing no. 2018xxxx.

2. Previously Approved Documents: If the Plan's filing includes changes or revisions to a grievance system document the Department approved previously, provide the eFile number(s) associated with the most recently approved version of the document.

- If the Plan is providing only a grievance form or template (Exhibit W-2), identify the eFile number affiliated with the Plan policy that relates to the form.

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- 3. Scope of Policy, Procedure, or Document:** If the Plan is providing a policy, procedure or document for review, identify the scope of the policy, procedure or document, including whether the policy is comprehensive, i.e., demonstrates the Plan's compliance with all grievance provisions of the Act for all of the Plan's products, or if the policy is one of a series of Plan policies or documents developed to comply with the grievance provisions of the Act for a specific Plan product.
- One all-inclusive Grievance policy *is not required*; the Plan may use a group of separate policies to satisfy the requirements of the Act. The Plan may file one policy to satisfy specific provisions of the Act if the Plan has *additional, separate* policies for ensuring compliance with other grievance provisions of the Act identified in Tables A-H, attached.
 - Example: The Plan has a series of policies, procedures, and forms to ensure compliance with the grievance provisions of the Knox-Keene Act. This filing includes the Plan's policy and template enrollee correspondence for the expedited review of grievances. The policy and template correspondence apply only to the Plan's Medi-Cal line of business.
- 4. Impact on other Plan Documents:** Explain the effect of the proposed change on any other enrollee or provider-facing documents, including, but not limited to, the description of the Plan's grievance procedure and/or forms available to enrollees, and the evidence of coverage and/or disclosure form, or provider manual. Describe how:
- The change will be communicated to the affected audience;
 - The timing for communication of the change; and
 - Whether the change will necessitate revisions to other Plan documents.
- 5. Notice of Change:** If the Plan files a new or revised grievance system policy, procedure, or document, describe how and when the Plan will inform appropriate Plan personnel, vendors, and/or providers of the change.
- 6. Implementation of Change:** If the Plan files a new or revised grievance form or template correspondence, describe how and when the Plan will implement the change.
- 7. Use by Contracted or Subcontracted (Downstream) Entities:** Describe how the Plan will ensure downstream individuals or entities do not use or circulate the outdated policy, procedure, form, or template correspondence, replaced by the new or revised policy, procedure, form or template correspondence.
- 8. Application of Changes to Delegates:** If the Plan has delegated any portion of its grievance system responsibilities to another entity, include the name of the



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entity, and the eFile number of the contract wherein delegation was effected. Explain how the Plan will ensure changes described in this filing are applied to grievance system functions performed by the delegate.

9. Exhibits Included in Filing: Describe, and identify by name and Exhibit type, all documents submitted as part of the filing for consideration by the Department.

- **Do not** submit a previously approved, unchanged Exhibit W.
 - **Example:** If the Plan is revising *only* a grievance form, the Plan should only file the clean and redlined grievance form, Exhibit W-2, and should not submit unchanged Exhibits such as W-1, W-3, W-7, etc.

10. Other Information: Include any other information the Plan thinks would help the Department review this filing.

Exhibit W-1: Grievance Policies and Procedures

The Plan's grievance system must include provisions to ensure the adequate consideration and rectification of enrollee grievances, including grievance monitoring, tracking and reporting. See Sections 1368 and 1367.01(j), and Rule 1300.68. Pursuant to Section 1351(l) the Plan must provide a description of its grievance procedures and provide policies and procedures demonstrating compliance with Section 1368, and Rule 1300.68 for review by the Department at licensure and upon revision. See Sections 1352 and 1368, and Rules 1300.51(d)(W)(1) and 1300.68.

- Exhibit W-1:** Submit *new* or *revised* grievance policies and procedures as Exhibit W-1.
- Exhibit W-9:** The Plan *may* submit policies and procedures specific to Independent Medical Review (IMR) as Exhibit W-1 or Exhibit W-9. See Sections 1370.4 and 1374.30, Rules 1300.67.3(a), 1300.70.4 and 1300.74.30.
- Exhibit W-1/W-9 must include provisions that demonstrate compliance with each Section or Rule identified in Tables A through G, attached, as applicable. The Plan's policies and procedures must be reasonable and ensure adequate consideration of enrollee grievances. See Section 1368(a)(1). The Plan should only refer to the Table(s) applicable to the policy or procedure filed by the Plan.
 - Table A Grievance System: Standard Requirements
 - Table B Grievance System: Expedited Review
 - Table C Grievance System: Online Grievance System

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- [Table D](#) Grievance System: Arbitration
- [Table E](#) Grievance System: Response to DMHC Inquiry
- [Table F](#) Grievance System: Tracking, Monitoring, and Reporting
- [Table G](#) Grievance System: IMR

Exhibit W-2: Forms and Template Letters

The Plan must provide copies of its template grievance complaint forms for review by the Department at licensure and when the Plan revises previously approved forms or proposes a new form. See Sections 1351 and 1352, and Rule 1300.51(d)(W)(2). The Plan must also file all enrollee forms and template correspondence for grievances and independent medical review (IMR), to demonstrate compliance with the Act. See Rule 1300.52.4(a)(ii), and Tables A-H. Changes to the format of previously filed grievance system forms must be approved by the Department prior to use. See Section 1368(a)(3).

- [Exhibit W-2](#): Submit *new* or *revised* template Grievance and IMR forms and template correspondence as an Exhibit W-2.
 - [Examples](#) of Exhibit W-2 template forms/documents:
 - Grievance receipt acknowledgement letter;
 - Grievance resolution letter;
 - Section 1368.01(b) Enrollee Rights Urgent Grievance;
 - Section 1300.68.01(a)(2) Status of Urgent Grievance.
- [Exhibit W-10](#): The Plan *may* submit IMR specific forms or template letters as Exhibit W-2 *or* Exhibit W-10. IMR forms must comply with the Department APL 18-013.
 - [Examples](#) of IMR template forms/documents:
 - IMR forms/template letters specific to experimental/investigational treatments or services.
 - IMR forms/template letters specific to payment disputes for emergent or urgent services.
- [Exhibit W-12](#): The Plan *may* submit screenshots of online grievance forms and/or other documentation demonstrating compliance with Sections 1368.015 and 1368.016 as Exhibit W-2 *or* Exhibit W-12.

Exhibit W-3: Oversight Staff and Duties

The Plan's grievance system must include an officer designated with primary responsibility for the system, whether administered directly by the Plan or delegated to

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another entity. At licensure and upon any change, the Plan must identify this officer to the Department, and provide a description of the officer's duties and responsibilities with respect to the grievance system as a whole, and the carrying out of the Plan's grievance policies and procedures. See Sections 1352 and 1368(b) and Rules 1300.51(d)(W)(3) and 1300.68(b)(1).

- Exhibit W-3: Submit a *new* or *revised* Exhibit W-3 that 1) identifies the Plan officer responsible for the Plan's grievance system, and 2) describes the officer's duties and responsibilities with respect to the grievance system. Such duties and responsibilities must include, but are not limited to, continuous review of the grievance system results and operations, and identification of emergent patterns of grievances.
 - Changes to the officer or duties identified in Exhibit W-3 may trigger a Change in Key Personnel Filing. Refer to the Checklist for Health Care Service Plan Key Personnel Change available on the Plan's Portal to determine if the Plan must provide additional Exhibits, identified in that checklist.

Exhibit W-7: Grievance Policy for Linguistic and Cultural Needs

The Plan's grievance system must address the linguistic and cultural needs of its enrollee population and the needs of enrollees with disabilities. See Sections 1351(l), 1352, and 1367.04, Rules 1300.67.04 and 1300.68(b)(3).

- Exhibit W-7: Submit *new* or *revised* grievance policies for ensuring 1) the linguistic and cultural needs of enrollees, and the needs of disabled enrollees, are met, and 2) access and full participation of such enrollees in the grievance system as an Exhibit W-7.
- Exhibit W-7 must include provisions that demonstrate compliance with each Section or Rule identified in Table H.
 - Table H Grievance System Cultural and Linguistic Needs.

Exhibit W-11: Health Plan Complaint Contacts

The Plan must maintain primary points of contact with the Department to allow (1) an enrollee to seek assistance from the Plan or file a complaint (see Sections 1363.1, 1368.03(a), and 1300.68(b)(4)), (2) the Department to notify the Plan that a consumer has filed a grievance with the Department (see Rule 1300.68(g)), and (3) the Department to reach a Plan representative to discuss urgent consumer complaints, 24 hours a day, 7 days a week (See Rule 1300.68.01(b)). At licensure and upon any change, the Plan must provide the Department with these primary points of contact.

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- Exhibit W-11: Submit a *new* or *revised* Health Plan Complaint Contact form as Exhibit W-11. The form is available on the Plan's DMHC portal.

Exhibit W-13: Provider Complaint Unit Contacts

The Plan must maintain primary points of contact so (1) the Department can facilitate the submission, receipt, processing, and resolution of claims payment disputes submitted by non-contracting individual health professionals (See section 1371.30(b)) and 2) the Department can notify the Plan of, and/or investigate, a complaint or dispute about the Plan or its practices submitted by a health professional (see Section 1351(t) and Rule 1300.68(g)). At licensure and upon any change, the Plan must provide the Department with these primary points of contact.

- Exhibit W-13: Submit a *new* or *revised* Provider Complaint Unit Contact form as Exhibit W-13. The form is available on the Plan's DMHC portal.

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Grievance System Tables

The Sections and Rules identified in Tables A-H represent what issues, *at minimum*, the Plan is required to address when proposing a new or amended grievance policy, procedure, or other grievance system document. The policies and procedures of the Plan's grievance system must be reasonable and ensure adequate consideration of enrollee grievances. See Section 1368(a)(1). The Plan is strongly encouraged, but not required, to use Tables A-H as suggested below. By completing the Tables, the Plan creates a "Compliance Map" to assist licensing counsel in their review of the filing.

Purpose of Tables A through H:

- Tables A-H identify the grievance system requirements included in the Act, and provide citations for each such requirement.
 - One or more Table may apply to the Plan's grievance system document. The grievance system document filed by the Plan need only address the requirements applicable to the policy, procedure, form, template correspondence or other document filed by the Plan.
 - One all-inclusive policy or document *is not required*; the Plan may use a group of separate policies and documents to satisfy the requirements of the Act identified in Tables A-H.

How to Use Tables A through H:

- Review the Tables to determine which Table(s) applies to the grievance system document(s) provided by the Plan. Ensure the Plan's document addresses all applicable requirements of the Act prior to filing with the Department.
- Use the third column of the appropriate Table(s) to identify the location of the provision of the grievance document that satisfies the Section or Rule identified in the second column. (Populating the Table creates the "Compliance Map," and demonstrates compliance with the applicable provisions of the Act to the Department.)
- Attach the completed, applicable Compliance Map(s) to Exhibit E-1.
 - If the Plan does not include the applicable Compliance Map in its initial filing, Licensing Counsel may request the Plan submit a Compliance Map, as necessary to assist with review of the filing. See Section 1351(t) and Rule 1300.52.4(a)(ii).
- Medi-Cal Plans should affirm compliance with the Department of Health Care Services APL 17-006, concerning Medi-Cal product grievance systems, where appropriate, *except* as follows:

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- Appeals Resolution Timeframes: Although permitted by DHCS APL 17-006, any policy extending the review timeframes for Standard (30 day) and Expedited (72 hour) grievances, beyond the timeframes identified in Sections 1368 and 1367.01(h)(2) and Rules 1300.68 and 1300.68.01 is not complaint with the Act, and will not be approved by the Department.

- Enrollee Letters: For grievances involving delay/denial/modification/ approval of a requested service, the Plan must include the name and telephone number of the healthcare professional responsible for the determination in the determination letter issued to the enrollee. See Section 1367.01(h)(4). Although permitted by DHCS APL 17-006, any template grievance letter or policies concerning grievance letter content that does not strictly comply with Section 1367.01(h)(4) is not compliant with the Act, and will not be approved by the Department.

**Table A
Grievance System: Standard Requirements**

Requirement	Section or Rule	Provision, Paragraph, and/or Page of Plan Document Demonstrating Compliance
Definitions	1300.68(a)(1)	
	1300.68(a)(2)	
	1300.68(a)(3)	
	1300.68(a)(4)	
	1300.68(a)(4)(B)	
	1374.30(b)	
	1374.30(c)	
Provision of Member Grievance Materials	1367.042(a)(4)	
	1368(a)(2), 1300.68(b)(2)	
	1368(a)(3)	
	1300.68(b)(7)	
Dedicated Grievance Telephone Number	1300.68(b)(4)	
Records & Record Maintenance	1368(a)(7)	
	1300.68(b)(5)	
	1300.68(d)(6)	
	1300.85.1	
Grievance Filing Requirements	1368(a)(3)	
	1368.015	
	1300.68(b)(6)	
	1300.68(b)(9)	
No Discrimination	1300.68(b)(8)	
Response to Member Grievances:	1368(a)(4)(A); 1300.68(d)(1)	



**CHECKLIST FOR HEALTH CARE SERVICE PLAN
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Timeframes	1368.01(a)	
	1300.68(a)	
	1300.68(d)(3)	
Plan's Review Process	1367.01(e)	
	1367.01(f)	
	1367.01(g)	
	1368(b)(1)(B)	
	1300.67.3(a)(1)	
	1300.68(a)(4)(A)	
	1300.68(d)(2)	
Exempt Grievances	1300.68(d)(8)	
	1368(a)(4)(B)(i); 1300.68(d)(8)	
	1368(a)(4)(B)(ii)	
Acknowledgement Letter: Content	1368(a)(4)(A); 1300.68(d)(1)	
	1368.02(b); 1300.68(d)(7)	
Resolution Letter Content: All Determinations	1368(a)(5)	
	1368.02(b); 1300.68(d)(7)	
	1300.68(d)(3)	
Resolution Letter Content: Small, Individual, Large Group Only	1368(a)(4)(B)(ii)	
Resolution Letter Content: Determination based on Medical Necessity	1368(a)(5)	
	1300.68(d)(4)	
Provider Notification: Approval, Modification, Denial of Provider Request for Services	1367.01(h)(3)	
	1367.01(h)(4)	
Resolution Letter Content: Determination of Coverage Dispute	1368(a)(5)	
	1300.68(d)(5)	
Content of Response- Determination Service is Experimental/ Investigational	1370.4(c)(1)	
	1300.70.4(b)(1)	
Resolution Letter Content: Enrollee with Terminal Illness	1368.1(a)	
	1368.1(a)(1)	
	1368.1(a)(2)	
	1368.1(a)(3)	
	1368.1(b)	
Resolution Letter Content: Determination involves	1368(a)(6)	

**CHECKLIST FOR HEALTH CARE SERVICE PLAN
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Cancellation, Rescission, Nonrenewal		
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**Table B
Grievance System: Expedited Review**

Requirement	Section or Rule	Provision, Paragraph, and/or Page Demonstrating Compliance
Definitions	1367.01(h)(2)	
	1368(b)(1)(A)	
	1300.68.01(a)	
Required Procedures: Urgent Grievances	1368.01(b)	
	1300.68.01(a)(1)	
	1300.68.01(a)(2)	
	1300.68.01(a)(3)	
	1300.68.01(a)(4)	
	1300.68.01(b)(2)(A)	
	1300.68.01(b)(2)(B)	
Timeframe: Resolution of Urgent/Expedited Grievance	1367.01(h)(2)	
Compliance with Section 156.122 of Title 45 of the Code of Federal Regulations: Small Group, Large Group and Individual Products only	1368.01(c)	

**Table C
Grievance System; Online Grievance System**

Requirement	Section or Rule	Provision, Paragraph, and/or Page Demonstrating Compliance
Online Submission of Grievances	1368.015(a)	
Online Grievance Form	1368.015(c)(1)	
Website Content: Grievances.	1368.016	
Online Grievance Submission Procedure	1368.015(c)(2)	
	1368.015(c)(3)	
	1368.015(b)	
	1368.015(c)	

**Table D
Grievance System: Arbitration**

Requirement	Section or Rule	Provision, Paragraph, and/or Page Demonstrating Compliance
Definition	1300.73.21(d)	

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**CHECKLIST FOR HEALTH CARE SERVICE PLAN
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Disclosure of Arbitration Procedures	1363.1(a)	
	1373(j)	
	1300.63.1(c)(12)	
	1300.63.2(c)(15)	
Request for Mediation	1368(b)(9)	
Arbitration as Additional Remedy	1368(d)	
	1368(b)(9)	
Arbitration Expenses	1368(b)(9)	
Selection of Arbitrator	1373.19	
Requirements when Arbitrator is not a Professional Dispute Resolution Organization	1373.20(a)	
	1373.20(a)(1)	
	1373.20(a)(2)	
Dilatory Conduct	1373.20(b)	
Extreme Hardship Cases:	1373.20(c)(1)	
	1373.20(c)(2)	
	1373.20(c)(3)	
	1373.20(c)(4)	
Written Arbitration Decision	1373.21(a)	
	1373.21(b)	
	1373.21(c)	
	1373.21(e)	
	1300.73.21(b)	
	1300.73.21(c)	
Provision of Arbitration Decision to the Department	1300.73.21(a)(1)	
	1300.73.21(a)(2)	
Arbitration Reporting	1300.68(e)(1)	
	1300.68(f)	
	1300.68(i)	

**Table E
Grievance System: Response to DMHC Inquiry**

Requirement	Section or Rule	Provision, Paragraph, and/or Page Demonstrating Compliance
Timeframe: Response to DMHC Inquiry	1300.68(g)	
	1300.68(g)(6)	
	1300.68.01(b)	
Timeframe: Response to IMR Notification	1374.30(n)	
	1300.74.30(j)	
Timeframe: Expedited Response to DMHC, Urgent IMR/Grievances	1300.68(h)	
24/7 Plan Contact: Availability	1300.68.01(b)	

**CHECKLIST FOR HEALTH CARE SERVICE PLAN
GRIEVANCE SYSTEM**

24/7 Plan Contact: Decision Making Authority	1300.68.01(b)(1)	
	1300.68.01(b)(3)	
24/7 Plan Contact: Scheduling	1300.68.01(b)	
	1300.68.01(b)(2)(A)	
	1300.68.01(b)(3)	
Content: Response to DMHC Grievance Inquiry	1300.68(g)(1)	
	1300.68(g)(2)	
	1300.68(g)(3)	
	1300.68(g)(4)	
	1300.68(g)(5)	
Content: Response to IMR Notification	1374.30(n)(1)	
	1374.30(n)(2)	
	1374.30(n)(3)	
	1374.31(a)	
	1300.74.30(j)(1)	
	1300.74.30(j)(2)	
	1300.74.30(k)(1)	
	1300.74.30(k)(2)	
Notification to Department of Change/Modification of Benefit or Service Subject of an Urgent Grievances	1300.68.01(c)	
Implementation of Department Decision: Grievance	1368(b)(6)	
Implementation of Department Decision: IMR	1374.34(a)	
	1374.34(c)	

**Table F
Grievance System: Tracking, Monitoring, and Reporting**

Requirement	Section or Rule	Provision, Paragraph, and/or Page Demonstrating Compliance
Components of monitoring and assessment process	Section 1367.01(j)	
Requirement to Track and Monitor Grievances	1300.68(e)	
Procedures for Use of Grievance Reporting to Improve Grievance System.	1300.68(b)(1)	
System Requirements: Tracking and Monitoring	1300.68(e)(1)	
	1300.68(e)(2)	
Grievance Reporting	1368(c)	
	1300.68(f)(1)	
	1300.68(f)(2)	

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**CHECKLIST FOR HEALTH CARE SERVICE PLAN
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	1300.68(f)(3)	
	1300.68(f)(4)	
Grievance Reporting Form	1300.68(i)	
Pending Grievances	1300.68(a)(4)(B)	

**Table G
Grievance System: IMR**

Requirement	Section or Rule	Provision, Paragraph, and/or Page Demonstrating Compliance
Definitions	1374.30(b)	
	1374.30(c)	
Display/Notification of Right to IMR and IMR Procedure	1368(a)(5)	
	1374.30(e)	
	1374.30(i)	
	1374.30(m)	
	1300.68(d)(4)	
	1300.68.01(a)(1), 1300.74.30(b)	
	1300.70.4(a)	
	1300.70.4(b)	
IMR Eligibility	1300.74.30(a)	
	1300.70.4(a)	
	1370.4(a)(1)	
	1374.30(j)(1-3), 1300.74.30(b)	
	1300.70.4(b)(2)	
Timeframe: Filing IMR	1374.30(k)	
	1300.70.4(b)	
IMR Notification Content	1300.70.4(b)(1)	
	1300.70.4(c)	
	1300.70.04(d)	
	1300.74.30(d) (the form)	
	1300.74.30(d)(1-4)	
IMR Application Form	1374.30(l)	
	1374.30 (m)	
	1374.30(m)(1)	
	1374.30(m)(2)	
	1374.30(m)(3)	

**CHECKLIST FOR HEALTH CARE SERVICE PLAN
GRIEVANCE SYSTEM**

	1374.30(m)(4)	
IMR Notification Content- Expedited Review Requested	1300.70.04 (d)(5)	
	1374.31(a)	
DMHC Final Arbiter, Grievance v. IMR	1374.30(d)(2)	
	1374.30(d)(3)	
Notification to Member of Information Provided to IMR Organization	1300.74.30(j)(2)	
Implementation of IMR Decision	1374.34(a)	
	1374.34(c)	

**Table H
Grievance System: Cultural and Linguistic Needs**

Requirement	Section or Rule	Provision, Paragraph, and/or Page Demonstrating Compliance
Definition	1300.67.04(b)(2)	
Assistance Requirements	1300.67.04(c)(2)(D); 1300.68(b)(3)	
Availability: Translated Forms & Procedures	1300.67.04(c)(2)(D)(i)	
	1300.67.04(c)(2)(D)(ii)	
	1300.67.04(c)(2)(D); 1300.68(b)(7)	
Translation of Documents: Threshold Languages	1367.04(b)(1)(B)(iv); 1300.67.04(b)(7)(D)	
Notice of Oral/Written Translation Services	1367.042(a)(1)	
	1367.042(a)(2)	
	1367.04(b)(1)(B)(v)	
	1367.04(b)(1)(C)(i)	
	1367.04(b)(1)(C)(iii)	
Translation of Documents: Non-Threshold Languages	1367.04(b)(1)(C)(ii)	
	1367.041(a)(4) (Individual and Small Group only)	

	January	February	March	April	May	June	July	August	September	October	November	December
Quarterly Monitoring												
Documentation												
Checklist/Job Aid Review	*	*		*		*	*		*	*	*	
Training Material Review	*	*		*		*	*		*	*	*	
Case Audits	*	*		*		*	*		*	*	*	
Technology												
Downtime Monitoring	*	*		*		*	*		*	*	*	
Data Analytics												
Case Resolution Decision Trending	*	*		*		*	*		*	*	*	
Trending Analysis	*	*		*		*	*		*	*	*	
Timeliness	*	*		*		*	*		*	*	*	
Biannual Monitoring												
Documentation												
P&P Review	*	*		*	*	*	*		*	*	*	*
Workflow Validation	*	*		*	*	*	*		*	*	*	*
Staffing/Performance												
Inter-rater testing	*	*	*	*	*	*		*	*	*	*	
Skill set review/Skill Gap Analysis	*	*	*	*	*	*		*	*	*	*	
Technology												
Accessibility of data	*	*	*	*	*	*		*	*	*	*	
Cross-system Data Exchange Validation	*	*	*	*	*	*		*	*	*	*	
Data Analytics												
Case Volume Analysis	*	*	*	*	*	*		*	*	*	*	



APPENDIX B

Schedule of Plan Grievance Contacts (Standard and Expedited/Urgent Grievances).

Contact	Name	Title	Contact Hours	Phone Number	Email
Main Contact	Tiffany Smith, RN	Director of Care Coordination/ RN Clinical Risk Manager	24/7	954-405-4297	Tiffany.Smith@aidhealth.org
Backup Contact #1	Donna Stidham, RN	Chief of Managed Care	24/7	323-860-5325	DonnaS@aidhealth.org
Backup Contact #2	Scott Howell, DO	Medical Director	24/7	917-544-5619	Scott.Howell@aidhealth.org