Policy:	DD.2013
Title:	**Customer Service Grievance Process**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 10/31/2024*
Effective Date:	12/01/2016
Revised Date:	10/01/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the process by which the CalOptima Health Customer Service Department intake, address, resolve, and track Grievances from a Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. CalOptima Health Customer Service Department shall establish and maintain a Grievance process to intake, triage, and address a Member's, a Member's Authorized Representative, or Provider acting on behalf of the Member, expression of dissatisfaction and/or a request to file a Grievance for review and Resolution.

B. CalOptima Health Customer Service Department Grievance process shall distinguish an "Inquiry," which is a request for information that does not include an expression of dissatisfaction, from a Grievance which is a written or oral expression of dissatisfaction about any matter other than an Adverse Benefit Determination pursuant to Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates.

C. Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment, and that are resolved by the close of the next business day are exempt from the requirement from sending a written acknowledgment and response and shall be classified as an Exempt Grievance.

D. CalOptima Health Customer Service Department shall refer all potential medical quality of care issues identified through the Customer Service Grievance process to the CalOptima Health Grievance and Appeals Resolution Service (GARS) or the Quality Improvement Department for action. GARS' actions may include, but are not limited to, referral to the CalOptima Health Quality Improvement Department for review, in accordance with CalOptima Health Policy HH.1102: Member Grievance.

E. CalOptima Health Customer Service Department shall inform a Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, of the right to file a Grievance through CalOptima Health at any time, in accordance with Title 42 of the Code of Federal Regulations, Section 438.402(c)(2)(i).

F. CalOptima Health Customer Service Department shall not discourage the filing of Grievances. A Member, Member's Authorized Representative, or a Provider acting on behalf of a Member need not use the term "Grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance.

G. CalOptima Health Customer Service Department shall maintain records and logs of each standard and Exempt Grievance, including the date of receipt, name of complainant, Member's name and client identification number (CIN), nature of the Grievance, name(s) of the CalOptima Health staff who received the Grievance, and name of the CalOptima Health staff who resolved the Grievance and ensure Grievances are included in the aggregated Grievance data reported to the Department of Health Care Services (DHCS).

H. CalOptima Health Customer Service Department shall ensure that there is no discrimination against a Member, Member's Authorized Representative, or a Provider, acting on behalf of a Member on the grounds that the Member, Member's Authorized Representative, or a Provider, acting on behalf of a Member filed a Grievance.

III. PROCEDURE

A. Inquiry

1. If a Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, contacts the Customer Service Department, by telephone or in-person, and requests information pertaining to eligibility, benefits, or other CalOptima Health processes with no expression of dissatisfaction, it is an Inquiry, rather than a Grievance.

2. CalOptima Health Customer Service staff shall:

   a. Identify and document the nature of the Inquiry given by the Member, Member's Authorized Representative, or Provider acting on behalf of a Member;

   b. Categorize the Inquiry with the appropriate subject and category codes;

   c. Provide the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member with the requested information; and

   d. Close the Inquiry with the appropriate disposition codes.

B. Standard Grievance

1. A Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, can request to file a grievance to the Customer Service Department by telephone, or in person.

2. CalOptima Health Customer Service staff shall:

a. Identify and document the nature of the Grievance given by the Member, Member's Authorized Representative, or Provider acting on behalf of a Member;

b. Inform the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member of the Resolution timeframes;

c. Mark the grievance with the appropriate Priority Code (routine or urgent); and

d. Route the Grievance to the GARS Department. The GARS Department shall process the Grievance in accordance with CalOptima Health Policy HH.1102: Member Grievance.

3. The GARS Department shall continue to assist the Member, Member's Authorized Representative, or a Provider acting on behalf of a Member with any additional or immediate needs.

C. Exempt Grievance

1. A Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, may express dissatisfaction, or discontent, to the CalOptima Health Customer Service Department by telephone, or in person.

2. The CalOptima Health Customer Service Department staff shall:

a. Identify and document the nature of the dissatisfaction expressed by the Member, Member's Authorized Representative, or Provider acting on behalf of a Member;

b. Document all actions taken to address the dissatisfaction expressed by the Member, Member's Authorized Representative, or a Provider, acting on behalf of a Member, as well as the Resolution provided in response to the dissatisfaction expressed by the Member, Member's Authorized Representative, or Provider acting on behalf of the Member; and

c. If the Grievance is resolved by the close of the next business day, close the Grievance with the appropriate disposition codes.

3. If CalOptima Health Customer Service Department staff is unable to provide Resolution to the Member, a Member's Authorized Representative, or Provider acting on behalf of a Member, dissatisfaction or discontent by close of the next business day, the CalOptima Health Customer Service staff shall:

a. Educate the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, of Grievance rights, in accordance with CalOptima Health Policy HH.1102: Member Grievance, and inform the issue(s) will be referred to the GARS Department;

b. Inform the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member of the Resolution timeframes; and

c. If the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member agrees to refer the Grievance, route grievance to the GARS Department.

4. If the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member expressly declines to file the Grievance, Customer Service staff shall:

    a. Categorize the issue as a Grievance;

    b. Forward potential quality of care declined grievances to the CalOptima Health Quality Improvement Department for review.

    c. Continue to assist the Member, Member's Authorized Representative, or a Provider acting on behalf of a Member until the Grievance is fully resolved; and

    d. Close the Grievance with the "Declined Grievance/Resolved" disposition code.

D. Medi-Cal Rx Member Complaints and Grievances

1. CalOptima Health shall process pharmacy-related Complaints and Grievances for services rendered on or before December 31, 2021 and must be fully adjudicated by CalOptima Health in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates .

2. Pharmacy-related Complaints and Grievances received by CalOptima Health for Medi-Cal Rx services provided on or after January 1, 2022, must be transferred by CalOptima Health to the Medi-Cal Rx Customer Service Center (CSC) for resolution. CalOptima Health must make every effort to immediately forward Complaints and Grievances for timely and accurate resolution by the Medi-Cal Rx CSC.

3. Pharmacy-related Complaints and Grievances related to pharmacy services billed to CalOptima Health on medical or institutional claims will be handled by CalOptima Health GARS Department.

4. Complaints and Grievances received in writing must be appropriately triaged and mailed or faxed to the Medi-Cal RX CSC within three (3) calendar days.

E. Records and Reports

1. CalOptima Health Customer Service Department staff shall log the call into the core business system to document receipt of the Grievance, the disposition and Resolution provided to the Member, Member's Authorized Representative, or a Provider acting on behalf of a Member.

2. CalOptima Health Customer Service Department shall maintain a record in the core business system for each standard and Exempt Grievance, including the date of receipt, Member's name and client identification number (CIN), nature of the Grievance, the Resolution provided, and the Customer Service Representative's name who took the call and resolved the Exempt Grievance.

3. CalOptima Health Customer Service Department shall, on a monthly basis, provide an Exempt Grievance and "Declined Grievance/Resolved" report to GARS to be aggregated for tracking and trending purposes as with other Grievances.

4. CalOptima Health Customer Service and GARS Department management staff shall, on a monthly basis, review reports for tracking and trending of Exempt Grievances by Provider, Health Network and Grievance category.

5. CalOptima Health Customer Service Department shall ensure Exempt Grievances are incorporated in the monthly Grievance and Appeals Report.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health, Health Network Service Agreement
C. CalOptima Health Policy HH.1102: Member Grievance
D. CalOptima Health Policy HH.1103: Health Network Member Grievance and Appeal Process
E. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates
F. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-012: Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal RX (Supersedes APL 20-020)
G. Title 42 Code of Federal Regulations (C.F.R.), § 438.402(c)(2)(i)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/21/2017	Department of Health Care Services (DHCS)	Approved as Submitted
03/22/2021	Department of Health Care Services (DHCS)	Approved as Submitted
07/21/2021	Department of Health Care Services (DHCS)	Approved as Submitted
10/06/2022	Department of Health Care Services (DHCS)	Approved as Submitted
10/12/2022	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
12/03/2020	Regular Meeting of CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2016	DD.2013	Exempt Grievance Process	Medi-Cal
Revised	06/01/2017	DD.2013	Exempt Grievance Process	Medi-Cal
Revised	10/01/2018	DD.2013	Exempt Grievance Process	Medi-Cal
Revised	12/03/2020	DD.2013	Customer Service Grievance Process	Medi-Cal
Revised	12/01/2021	DD.2013	Customer Service Grievance Process	Medi-Cal
Revised	09/01/2022	DD.2013	Customer Service Grievance Process	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	10/01/2023	DD.2013	Customer Service Grievance Process	Medi-Cal
Revised	10/01/2024	DD.2013	Customer Service Grievance Process	Medi-Cal

IX. GLOSSARY

Term	Definition
Adverse Benefit Determination	Any of the following actions taken by CalOptima Health: 1. The denial or limited authorization of a requested service, including determinations based on the type or Level of Service, Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a 'clean claim' at 42 CFR section 447.45(b) is not an Adverse Benefit Determination. 4. The failure to provide services in a timely manner. 5. The failure to act within the required timeframes for standard Resolution of Grievances and Appeals. 6. For a resident of a rural area with only one MCP, the denial of the Member's request to obtain services outside the network. 7. The denial of a Member's request to dispute financial liability.
Authorized Representative	Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
Complaint	A complaint is the same as a Grievance. If CalOptima Health is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Exempt Grievance	Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response.
Grievance	Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not

Term	Definition
	limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Inquiry	A request for information that does not include an expression of dissatisfaction. Inquiries may include, but not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Provider	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Resolution	The grievance has reached a final conclusion with respect to the Member or Provider's submitted Grievance.
Threshold Languages	The non-English threshold and concentration standard languages in which Contractor is required to provide written translations of Member Information, as determined by DHCS.