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<tr><td colspan="2">CENCAL HEALTH
DEFINITION ADDENDUM</td></tr>
<tr><td>Title: Grievance & Appeal System Definition Addendum</td><td>Type: Grievance & Appeal System Attachment A</td></tr>
<tr><td>Effective Date: 01/2024</td><td>Last Revised Date: 12/2023</td></tr>
<tr><td>Director/Officer Signature:

Eric Buben
Director of Member Services</td><td>Officer Signature:

Van Do-Reynoso, MPH, PhD
Chief Customer Experience Officer and
Chief Health Equity Officer</td></tr>
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I. Definitions:

A. **Adverse Benefit Determination (ABD):** Means any of the following actions taken by CenCal Health:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of a covered service, medical necessity, appropriateness, setting, or effectiveness of a covered service;
2. The reduction, suspension, or termination of a previously authorized covered service;
3. The denial, in whole or in part, of a payment for a covered 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" is not an Adverse Benefit Determination;
4. The failure to provide covered services in a timely manner;
5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals;
6. The denial of the Member's request to obtain services out of network when a Member is in an area with only one Medi-Cal managed care health plan; or
7. The denial of a Member's request to dispute financial liability.

B. **Appeal:** A review by CenCal Health of an ABD, which includes one of the following actions:

1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered service;
2. A reduction, suspension, or termination of a previously authorized service;

3. The denial, in whole or in part, of payment for a covered service, except payment denials based solely because the claim does not meet the definition of a clean claim;
4. Failure to provide services in a timely manner; or
5. Failure to act within the timeframes provided in 42 CFR section 438.408(b).

C. **Discrimination Grievances:** Any complaint or grievance alleging discrimination prohibited by State non-discrimination law, including, without limitation, the Unruh Civil Rights Act and Government Code section 11135, and federal non-discrimination law, including, without limitation, Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; Sections 504 and 508 of the Rehabilitation Act of 1973, as amended; Titles II and III of the Americans with Disabilities Act of 1990, as amended; and Section 1557 of the Patient Protection and Affordable Care Act of 2010.

D. **Downstream Subcontractor:** An individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.

E. **Downstream Subcontractor Agreement:** A written agreement between a Subcontractor and a Downstream Subcontractor or between any Downstream Subcontractors. The Downstream Subcontractor Agreement must include a delegation of CenCal Health's and Subcontractor's duties and obligations under the contract between DHCS and CenCal Health.

F. **Exempt Grievance:** Grievances received over the telephone that are not coverage disputes or disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day. .

G. **Expedited Appeal:** An Appeal that Plan determines, or the requesting provider indicates, that taking time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. Expedited Appeals must be resolved within 72 hours. Members are notified of the Plan's decision both orally and in writing.

H. **Expedited Grievances** A Grievance that Plan determines, or the requesting provider indicates, that taking time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. Expedited Grievances must be handled and resolved within 72 hours.

I. **Grievance:** An oral or written expression of dissatisfaction about any matter other than an Adverse Benefit Determination and may include, but is not limited to, quality of care or services provided, interpersonal relationships with a provider or Plan's staff/employees, 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 the Plan to make an authorization decision.

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

K. **Member or Enrollee:** A Potential Member who has enrolled with CenCal Health.

L. **Network Provider:** Any provider or entity that has a Network Provider Agreement with CenCal Health, CenCal Health's Subcontractor, or CenCal Health's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under the contract between CenCal Health and DHCS. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.

M. **Network Provider Agreement:** A written agreement between a Network Provider and CenCal Health, Subcontractor, or Downstream Subcontractor.

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

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

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

Q. **Notice of Action (NOA) or Notice of Adverse Benefit Determination (NABD):** A formal letter informing the Plan Member of an Adverse Benefit Determination. Members may request at no charge copies of all documents and records

relevant to the Plan decision including criteria and/or guidelines used to make the decision or determination (as noted in 42 CFR section 438.915). CenCal Health is only required to disclose the criteria or guidelines for the specific procedures or conditions requested. CenCal Health may charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines pursuant to Health & Safety Code section 1363.5, limited to copying and postage costs. The plan may also make the criteria or guidelines available through electronic communication means.

R. **Notice of Appeal Resolution (NAR) Letter:** The NAR is a written response to a Member's Appeal. The NAR letter shall contain CenCal Health's decision on the Appeal and date of review.

1. If the Appeal resolution upholds the Plan's original determination, or is not otherwise wholly in the Member's favor, the following applies:

   a. If the Plan's determination is based in whole or in part on medical necessity, the Plan shall include the reasons for its determination and clearly state the criteria, clinical guidelines, or medical policies used to reach such determination.

   b. If the Plan's determination specifies the requested services is not a covered benefit, the Plan shall include the provision in the DHCS contract and/or the Evidence of Coverage-Member Handbook that excludes the services. The response shall identify the document and page where the provision is found, direct the Member to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested.

   c. The NAR must contain the "Your Rights" Attachment if the decision made was to uphold the original decision (see DHCS template of NAR-Uphold).

2. If the Appeal resolution overturns the Plan's original determination in favor of the Member, the following applies:

   a. The NAR shall include CenCal Health's decision and date of completion. The Plan shall also ensure the written response contains a clear and concise explanation of the reason, including the reason for why the decision was overturned. (See DHCS template of NAR for overturn language.)

S. **Potential Member or Potential Enrollee:** A Medi-Cal recipient who resides in CenCal Health's service area and is subject to mandatory enrollment, or who may voluntarily elect to enroll, but is not yet enrolled, in a Medi-Cal managed care health plan, and is in one of the aid codes specified by DHCS.

T. **Quality Improvement and Health Equity Committee (QIHEC)**: A committee facilitated by CenCal Health's medical director, or the medical director's

designee, in collaboration with the Health Equity officer, to meet at least quarterly to direct all QIHETP findings and required actions.

U. **Quality Improvement and Health Equity Transformation Program (QIHETP)**: The systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in applicable laws, regulations, and the Plan's contract with DHCS.

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

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

X. **Subcontractor:** An individual or entity that has a Subcontractor Agreement with CenCal Health that relates directly or indirectly to the performance of CenCal Health's obligations under the contract between DHCS and CenCal Health. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

Y. **Subcontractor Agreement:** A written agreement between CenCal Health and a Subcontractor. The Subcontractor Agreement must include a delegation of CenCal Health's duties and obligations under the contract between DHCS and CenCal Health.

II. **References**:

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

III. **Cross Reference:**

A. Policy and Procedures (P&P):

1. MS-23: Appeals
2. MS-22: Grievances
3. MS-24: Grievances & Appeals Communication and Education
4. MS-25: Grievances & Appeals Monitoring and Oversight

B. Program Documents:

1. Provider Manual – Grievance & Appeals Section

IV. Attachments: N/A

Revision History:

Revision Date	Leaders who Reviewed and Approved Revisions	Reason for Revisions	Revision Effective Date	DHCS Approval Date
12/2023	Eric Buben, Director of Member Services	Checked-Out for 2024 Integration	01/2024	N/A
07/2023	Eric Buben, Director of Member Services	Established	Upon DHCS Approval	12/2023