

Member Grievance Policy

For the State of California

Introduction

Family Care encourages its members to resolve any complaints or grievances through the procedures outlined in this Grievance Policy. Grievances may be filed, and grievance forms can be obtained by mail, fax, telephone, or online as outlined below. If filing by mail or fax, please use the Grievance Form enclosed in your membership packet or print the form posted on the web.

- » If by mail, send to Family Care, Attention: Sam Hamadeh, Director of Quality Assurance - Grievances, 11111 Richmond Ave., Ste. 200, Houston, TX 77082.
- » If by fax, submit the completed form to **(713) 414-4953**. Grievances may be submitted by fax only during normal business hours, excluding national holidays. Normal business hours are:

Monday – Thursday	8:00AM – 7:00PM Central
Friday	8:00AM – 1:00PM Central
- » If by telephone, call **(800) 853-9594**.
- » If via the Internet, complaints can be emailed to: **compliance@familycarecard.com** or the Grievance Form can also be completed and submitted online at **www.servicemyplan.com** or **www.familycarecard.com**.

As a part of its Grievance Policy, Family Care will send an Annual Notice of Grievance Procedures to its members informing them of the California Department of Managed Health Care’s (“Department”) review process, the Department’s toll-free number and website, as well as Family Care’s Grievance Policy.

Family Care’s Grievance Policy addresses the linguistic and cultural needs of its member population, as well as the needs of members with disabilities. The system ensures all members have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency, or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems, and other devices that aid disabled individuals to communicate. Members may file a grievance under this Grievance Policy for up to one hundred and eighty (180) calendar days following any incident or action which gives rise to the member’s dissatisfaction.

Family Care is responsible for and will resolve service-related problems, including availability and accessibility of providers, pricing or billing disputes, the sales process, and other service-related problems. Family Care is not responsible for resolving quality of care-related issues or providing medically necessary healthcare coverage to members. Family Care will assist members in identifying and contacting the appropriate state professional licensing agency to report quality of care–related problems (e.g. the Medical Board of California, Dental Board of California, Department of Health Services, etc.).

Documentation

1. Family Care will maintain a written record of each grievance submitted under this Grievance Policy. The written record shall include: the date the grievance was received; the name of the Family Care representative that processed the grievance; a summary or other documents explaining the nature of the grievance, and a summary of the resolution.
2. Family Care will retain copies of grievances, responses, and resolutions for five years. When applicable, the records shall contain all documents, evidence and other relevant information upon which Family Care relied in reaching its decision.
3. Grievance forms shall be available as outlined above. Additionally, Family Care will have the Grievance Policy and Grievance Forms posted on its websites and included in the member packets and provider packets, so that members will have access to these forms in their initial packet as well as at each contracting provider's office or facility.
4. Grievances filed under this Grievance Policy shall not affect the member's status in any way. Family Care will enforce a strict no-tolerance policy against discrimination based upon the filing of a grievance under this Grievance Policy.
5. Members may file a grievance under this Grievance Policy for up to one hundred and eighty (180) calendar days following any incident or action which gives rise to the member's dissatisfaction.

Response & Resolution

1. Grievances received under this Grievance Policy shall be acknowledged by written response within five (5) calendar days. The written response will advise the member that their grievance has been received, the date of receipt, and provide the names of Family Care's department and representative, and telephone number and address of the Family Care representative who may be contacted about the grievance. All grievances will be resolved within thirty (30) calendar days from submission and will be reviewed from time to time by Family Care's officers and governing body to identify patterns regarding grievances as presented by the applicable management and supervisory staff. A clear and concise written response to the member will be provided within thirty (30) calendar days.
2. Notwithstanding section one (1) above, grievances received by telephone, facsimile, email or online that are resolved by the close of the next business day, will not be answered by written acknowledgment and response. Family Care shall maintain a log of all grievances that do not require a written acknowledgement containing the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of resolution, and the Family Care representative's name who took the call and resolved the grievance. The information contained in this log shall be periodically reviewed by Family Care.
3. Grievance reports will be shared quarterly with the appropriate management and supervisory staff responsible for the grievance to ensure member and provider concerns are addressed.

Grievance Tracking & Reporting

1. Family Care, through its responsible representatives, shall monitor the number of grievances received and resolved; whether the grievance was resolved in favor of the member or Family Care; and the number of grievances pending over thirty (30) calendar days. Family Care will distinguish complaints by whether a member grievance is pending at: (1) Family Care's internal grievance system; (2) the Department's consumer complaint process; (3) the Department's Independent Medical Review system; (4) an action filed or before a trial or appellate court; or (5) other dispute resolution process.
2. Family Care will track the total number of grievances received, pending and resolved in favor of the member at all levels of grievance review and to describe the issue or issues raised in grievances as (1) coverage disputes, (2) complaints about access to care (including complaints about the waiting time for appointments), and (3) complaints about the quality of service, and (4) other issues.
3. Family Care is not responsible for resolving quality of care-related issues or providing medically necessary healthcare coverage to members. Family Care will assist members in identifying and contacting the appropriate state professional licensing agency to report quality of care-related problems (e.g. the Medical Board of California, Dental Board of California, Department of Health Services, etc.).

Quarterly Reports Submitted to the Department

1. A quarterly report shall be submitted to the Department describing grievances that were or are pending and unresolved for thirty (30) days or more. The report shall be prepared for the quarters ending March 31st, June 30th, September 30th and December 31st of each calendar year. The report shall also contain the number of grievances referred to external review processes, such as the Department's complaint or Independent Medical Review system, or other external dispute resolution systems, known to Family Care as of the last day of each quarter.
2. The quarterly report filed by Family Care shall include:
 - A Family Care's name, quarter and date of the report;
 - B The total number of grievances filed by members that were or are pending and unresolved for more than thirty (30) calendar days at any time during the quarter;
 - C A brief explanation of why the grievance was not resolved in thirty (30) days, and indicate whether the grievance was or is pending at: (1) Family Care's internal grievance system; (2) the Department's consumer complaint process; (3) the Department's Independent Medical Review system; (4) court; or (5) other dispute resolution processes;
 - D The nature of the unresolved grievances listed as either (1) coverage disputes; (2) complaints about access to care (including complaints about the waiting time for appointments); (3) complaints about the quality of service; and (4) other issues. All issues reasonably described in the grievance shall be separately categorized.
 - E The quarterly report shall not contain personal or confidential information with respect to any member.
3. Prior to submitting the quarterly report to the Department, the report shall be verified by an officer authorized to act on behalf of Family Care. The report shall be submitted in writing or through electronic filing to the Department's Sacramento Office to the attention of the Filing Clerk no later than thirty (30) days after each quarter. The quarterly report shall not be filed as an amendment to Family Care's application.
4. Family Care's grievance reports shall be filed quarterly with the Department in the form specified by California law.

Urgent Grievances

Family Care expedites review of urgent grievances, which includes cases involving an imminent and serious threat to the health of the member, including but not limited to severe pain, potential loss of life, limb, or major bodily functions. The request may be initiated by the member, member's representative or provider ("requestor"). To have your grievance expedited, call **(800) 853-9594** and tell the Family Care representative that you are requesting an expedited review for an urgent grievance.

During normal office hours, Supervisors in the Member Services Department answer the grievance calls and callers may be placed on hold. On hold wait times may vary, but Family Care strives to keep wait times to no longer than five (5) minutes per call. Family Care shall respond to any grievance, urgent or non-urgent, that is left as a message during normal office hours within thirty (30) minutes after initial contact. Family Care shall respond to any non-urgent grievance that is left as a message during other than normal business hours within four (4) hours after initial contact, and shall respond to any urgent grievance that is left as a message during other than normal business hours within one (1) hour after initial contact.

For urgent grievances filed after normal working hours or on weekends or holidays, please leave a message that you are requesting an expedited review for an urgent grievance. Family Care shall inform the requestor over the phone of the right to immediately contact the Department regarding the grievance without going through Family Care's normal grievance procedure. Family Care shall send the member and Department a written statement on the disposition or pending status of the grievance, dispute or appeal within seventy two (72) hours from receipt of an urgent grievance.

Family Care shall resolve urgent grievances received during normal business hours no later than seven (7) business days after receipt, and during other than normal business hours no later than ten (10) business days after receipt.

To be clear, in any case determined by the Department to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, or in any other case where the Department determines that an earlier review is warranted, a subscriber or member shall not be required to complete the grievance process or to participate in the process for at least thirty (30) days before submitting a grievance to the Department for review. When determining whether a grievance constitutes an urgent grievance, Family Care representatives will ask each requestor whether, and to what degree, the inquiry involves an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function. When determining the response time to urgent grievances, Family Care will prioritize responses to urgent grievances over all other grievances or inquiries and will prioritize responses to multiple urgent grievances based on the requestor's description of the member's medical condition and the described degree of urgency involved with the member's medical condition. Urgent grievances with a higher degree of urgency will be prioritized over urgent grievances with a lower degree of urgency.

Member's Right to Submit Grievance Directly to the Department

1. 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 1.800.853.9594 (TDD: 713.414.4988; Toll free TDD: 866.545.1155) 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.HMO.2219) and a TDD line (1.877.688.9891) for the hearing and speech impaired. The Department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.
2. Upon notification from the Department that a Consumer has filed a grievance, Family Care will provide the following documents to the Department within five (5) calendar days:
 - A A written response to the issues raised by the grievance.
 - B If the grievance was first filed with Family Care, a copy of Family Care's original response sent to the member regarding the grievance.
 - C A complete and legible copy of all factual records related to the grievance.
 - D All other information used by Family Care or relevant to the resolution of the grievance.
 - E Any other information deemed necessary and appropriate by Family Care's management for the resolution of the grievance.