Policy:	MA.9002
Title:	**Enrollee Grievance Process**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 01/29/2025*
Effective Date:	10/01/2005
Revised Date:	12/31/2024
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima Health shall address and resolve an Enrollee's Grievance and Integrated Grievances involving Medi-Cal and Medicare covered services and benefits, in accordance with applicable statutory provisions, and the regulatory and contractual requirements of the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS).

II. POLICY

A. CalOptima Health shall establish and maintain a process that addresses the receipt, handling, and disposition of Grievances and Integrated Grievances (effective January 1, 2023), in accordance with applicable statutes, regulations, contractual requirements, and this Policy.

B. Grievance and Appeals Resolution Services (GARS) staff shall review and investigate Grievances. Subject to the requirements in the Addendum Guidance for Applicable Integrated Plans effective January 1, 2023, understanding that wherever the Part C & D Guidance refers to a "Grievance," the statements and guidance apply equally to Integrated Grievances for CalOptima Health. Therefore, the term Grievance in this policy respectfully applies, where/when appropriate, to the Integrated Grievances also.

C. Subject to the provisions of this Policy, a Grieving Party has the right to file a Grievance involving the express dissatisfaction with any aspect of the operations, activities, or behavior of CalOptima Health or its delegated entity(s) in the provision of health care or prescription drug services or benefits, regardless of whether remedial action is requested.

1. Grievances may involve, but are not limited to the following instances:

   a. An Enrollee's involuntary disenrollment initiated by CalOptima Health;

   b. A change in premiums or cost sharing arrangements from one contract year to the next;

   c. Lack of quality of the care received;

   d. Plan benefit design;

e. Difficulty contacting CalOptima Health via phone;

f. Interpersonal aspects of care;

g. Dissatisfaction with the service of a personal care aide;

h. CalOptima Health's Appeals process;

i. CalOptima Health's decision not to expedite a coverage or Appeal request;

j. General dissatisfaction about a co-payment amount, but not a dispute about the amount the Enrollee paid or is billed;

k. General issues about a drug not being on the formulary or listed as an excluded drug; or

l. Calculation of True Out-of-Pocket (TrOOP) costs for Medicare Part D drugs. An Enrollee may track TrOOP expenditures for covered Part D drugs in accordance with CalOptima Health Policy MA.6109: True Out-of-Pocket (TrOOP) Expenditures.

D. Subject to the provisions of this Policy, decisions made under the Grievance process are not subject to Appeal.

E. A Grieving Party must file a Grievance (including Quality of Care Grievances), verbally or in writing, no later than sixty (60) calendar days after the event or incident that precipitates the Grievance through December 31, 2022. Thereafter, the Grieving Party may file a Grievance at any time.

E. Other CalOptima Health departments, Health Networks and Providers shall respond to a GARS staff request for information relating to a Grievance within the timeframe specified by GARS.

F. Enrollee Notice

1. CalOptima Health shall notify an Enrollee of the Grievance process upon initial enrollment, and annually thereafter, in the OneCare Member Handbook/Evidence of Coverage.

2. The Customer Service Department shall inform an Enrollee of the Grievance process upon the Enrollee's involuntary disenrollment from OneCare in accordance with CalOptima Health Policy MA.4004: Member Disenrollment.

3. The CalOptima Health Utilization Management Department or the Enrollee's Health Network shall notify an Enrollee of the Grievance process upon denial of the Enrollee's request for an expedited review.

4. CalOptima Health and a Health Network shall inform an Enrollee of the Grievance process upon the Enrollee's request for such information.

G. Upon request from an Enrollee or Provider, GARS staff shall provide:

1. Information on how an Enrollee may file a Grievance;

2. The OneCare Member request, Appeal, or Grievance Form to an Enrollee, or a Provider; and

3. Assistance to an Enrollee who wishes to file a Grievance.

H. CalOptima Health shall ensure that there is no discrimination against an Enrollee on the basis that such Enrollee filed a Grievance, in accordance with CalOptima Health Policy HH.1104: Complaints of Discrimination.

I. CalOptima Health shall ensure that Enrollees have equal access to, and can fully participate in, the Grievance process by providing assistance to Enrollees with limited English proficiency, vision disorders, or other communicative impairments in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services, as follows:

1. Translation of forms and responses;

2. Interpretation services;

3. Telephone relay systems; and

4. Other reasonable accommodations, as appropriate.

J. CalOptima Health shall maintain Enrollee Confidentiality throughout the Grievance process.

K. CalOptima Health may consult with its legal counsel prior to responding to an Enrollee's Grievance.

L. A Grieving Party may file a Grievance regarding quality of care to CalOptima Health or to the Quality Improvement Organization (QIO).

M. If a Grievance involves multiple issues, CalOptima Health shall process each issue separately and simultaneously under the appropriate process.

N. CalOptima Health Customer Service shall notify Enrollees about any changes to its Grievance procedures thirty (30) days in advance of the effective date of change.

O. Disputes on rewards, incentives, or the reward program shall be treated as a Grievance and handled under provisions of this Policy.

P. CalOptima Health is responsible for reaching out to and engaging Members who are identified to be eligible for Enhanced Care Management (ECM), in accordance with CalOptima Health Policy GG.1353: CalAIM Enhanced Care Management Service Delivery.

III. PROCEDURE

A. Parties to a Grievance

1. An Enrollee , an individual appointed by the Enrollee (e.g., relative, friend, advocate, attorney), or any person authorized under state or other applicable law acting as the Enrollee's Authorized Representative may file a Grievance. If an Authorized Representative files a Grievance, he or she shall submit documentation of such appointment, as follows:

a. Appropriate legal documents, or authority, supporting such appointment; or

b. Appointment of Representative Form or equivalent written notice (Representative Form) signed by both the Enrollee and the Enrollee's Authorized Representative, except if an attorney acts as the Enrollee's Authorized Representative. If an attorney acts as the Authorized Representative, the Authorized Representative may submit a Request for Appointment of Representative Form, or equivalent written notice, signed by the Enrollee only.

c. If a Representative Form(s) is not received or is defective, CalOptima Health shall follow case dismissal procedures outlined in Desktop Procedure (DTP): Enrollee Case Dismissal Process.

2. A court acting in accordance with state or other applicable laws can authorize an individual to act on behalf of the Enrollee in filing a Grievance.

a. Authorized Representatives could include, but is not limited to a court appointed guardian, individual with durable power of attorney, a health care proxy, a person designated under a health care consent statute, executor of an estate.

b. The Authorized Representative shall produce and submit appropriate legal papers supporting his or her appointment under state law (a Representative Form is not required).

B. Filing a Grievance

1. A Grieving Party may file a Grievance:

a. Verbally, by telephone, or in person with the Customer Service Department; or

b. In writing to the GARS department.

2. A Grievance shall be considered received on the date and time:

a. CalOptima Health initially stamps a document received by regular mail;

b. A delivery service (that has the ability to track when a shipment is delivered) delivers the document;

c. A faxed document is successfully transmitted to CalOptima Health, as indicated on the fax transmission report;

d. A verbal request is made by telephone with Customer Service;

e. A message is left on CalOptima Health's voicemail system (if a voicemail system is utilized to accept the Appeal request or supporting statements after normal business hours); or

f. A Grievance is received through CalOptima Health's website.

3. Expedited Grievance

a. A Grieving Party has the right to request an expedited Grievance or fast complaint if:

i. An expedited request for an Organization or Coverage Determination is denied, or an extension is taken;

ii. CalOptima Health determines that an Enrollee's request for an expedited Appeal fails to meet expedited criteria, in accordance with CalOptima Health Policy MA.9004: Expedited Pre-Service Integrated Appeal and decides to process the Enrollee's request as a standard Appeal, in accordance with CalOptima Health Policy MA.9015: Standard Integrated Appeals; or

iii. CalOptima Health determines that it requires a fourteen (14)-day extension to process an Enrollee's request for a standard or expedited pre-service Appeal.

4. Any unit within CalOptima Health or a delegated entity not responsible for processing Grievances that incorrectly receives a Grievance, shall submit such request to the CalOptima Health Grievance and Appeals Resolution Services email inbox: grievancemailbox@caloptima.org, as expeditiously as possible for requests submitted in writing, or transfer to the CalOptima Health Customer Service Department for verbal requests.

C. Grievance Timeframe

1. Standard Grievance

a. Subject to the provisions of this Policy, CalOptima Health shall complete the investigation and resolve a Grievance (including Quality of Care Grievances) filed by a Grieving Party, as expeditiously as the Enrollee's case requires, based on the Enrollee's health status, but no later than thirty (30) calendar days after receipt of such request, unless a fourteen (14) calendar day extension is requested by the Grieving Party or if CalOptima Health justifies a need for additional information and documents how the delay is in the best interest of the Enrollee.

i. If CalOptima Health determines that an extension will be taken, GARS staff shall promptly notify the Enrollee:

a) Verbal Notification: Notify the Grieving Party of the decision to extend the timeframe for resolving the Grievance, verbally, no later than one (1) business day from such decision; and

b) Written Notification: Notify the Enrollee of the decision to extend the timeframe for resolving the Grievance, in writing, no later than two (2) calendar days of the verbal notice and explain the reason for the extension and the Enrollee's right to request an expedited Grievance, or fast complaint, if the Enrollee disagrees with the time extension.

b. The standard Grievance processing timeframe begins when CalOptima Health, any unit within CalOptima Health, or a delegated entity (including those not responsible for processing the request) receives a Grievance.

2. Expedited Grievance (i.e., Fast Complaint)

a. Subject to the provisions of this Policy, CalOptima Health shall complete the investigation and resolve an expedited Grievance filed by a Grieving Party, as expeditiously as the Enrollee's case requires, based on the Enrollee's health status, but no later than twenty-four (24) hours after receipt of such request.

b. The expedited Grievance processing timeframe begins when the appropriate CalOptima Health department receives such request.

D. Grievance Processing

1. Upon receipt of a Grievance, GARS staff shall:

a. Enter the information in the database; and

b. Contact the Enrollee to obtain any missing information or evidence concerning the Grievance and enter such information into the database.

2. Except in the case of an expedited Grievance, GARS staff respond to the Grievance in writing, by sending a Grievance Acknowledgement Letter to the Enrollee within five (5) business days after CalOptima Health's receipt of the Grievance. The Grievance Acknowledgement Letter shall:

   a. Confirm receipt of the Grievance;

   b. Provide the name of the GARS staff assigned to the Grievance; and

   c. Indicate the estimated timeframe to research and resolve the Grievance.

3. If written and signed documentation of an appointment or authorization of representation from the enrollee is not received for those grievances filed by someone other than the enrollee by the thirty (30) calendar day resolution or fourteen (14) calendar day extension standard timeframe, or the twenty-four (24) hour expedited timeframe, CalOptima Health will not undertake a review or issue a decision until or unless such documentation is obtained.

   a. GARS staff shall request, in writing, that the requestor submit documentation of the requestor's status as the Enrollee's Authorized Representative.

   b. If CalOptima Health does not receive documentation of the requestor's status as the Enrollee's Authorized Representative, GARS staff shall make at least two (2) telephone calls to the requestor in an attempt to obtain the documentation.

4. If CalOptima Health determines that it misclassified an Enrollee's Grievance as an Appeal, it shall notify the Enrollee, in writing, of the misclassified Grievance, and shall process the reclassified Grievance through the Grievance process. CalOptima Health shall consider the date of receipt of the original request as the date of receipt of the Grievance.

E. Grievance Investigation

1. The GARS staff shall forward a Member Complaint Referral to the responsible department, Health Network, or Provider, as applicable, for investigation and resolution.

2. The responsible department, Health Network, or Provider shall respond to the GARS staff within the timeframe specified by the referring GARS staff.

3. Upon receipt of the response regarding the investigation and resolution of a Grievance, from the applicable department, Health Network, or Provider, the GARS Director or his or her Designee shall review the Grievance for completeness and appropriate designation.

F. Grievance Resolution

1. Individuals making decisions on Grievances must be individuals who:

   a. Were neither involved in any previous level of review or decision-making, not a subordinate of any such individual; and

   b. If deciding any of the following, have the appropriate clinical expertise, in treating the Enrollee's condition or disease:

i. A Grievance regarding denial of expedited resolution of an Integrated Appeal.

ii. A Grievance that involves clinical issues.

2. GARS shall prepare, in writing, a resolution letter, addressing all issues raised in the Grievance and written in a manner that is understandable to the Enrollee, upon completion of the investigation.

   a. Standard Grievance (Including Quality of Care Grievances): GARS staff shall provide the Grieving Party a Grievance Resolution Letter no later than thirty (30) calendar days after receipt of the Grievance, or no later than forty-four (44) calendar days if an extension is applied.

   b. Expedited Grievance: GARS staff shall provide the Grieving Party verbal notification of the expedited Grievance decision no later than twenty-four (24) hours after receipt of such request, and provide the Grieving Party, in writing, a Grievance Resolution Letter, no later than three (2) calendar days of the verbal notification.

   c. If a Grievance (including Quality of Care Grievances) was filed by the Enrollee's Authorized Representative, the Authorized Representative must be notified.

3. CalOptima Health shall take immediate action to implement the decision, in accordance with the Grievance Resolution Letter

4. CalOptima Health shall consider a Grievance to be closed when:

   a. The problem is resolved;

   b. CalOptima Health takes appropriate action to implement the decision; or

   c. The Enrollee withdraws the Grievance.

5. Upon closure of the Grievance, GARS staff shall close the case in the database by entering the case summary, closure date, category, and resolution status.

G. Quality of Care Grievances

1. If a Grievance involves quality of care, GARS staff shall send a Quality Improvement referral to the Quality Improvement (QI) Department for investigation in accordance CalOptima Health Policy GG.1611: Potential Quality Issue Review Process.

2. CalOptima Health shall respond to a Grievance related to quality of care, in writing, regardless of whether the Grievance is filed orally, or in writing. The written response shall include a description of the Enrollee's right to file a written Grievance with the QIO.

   a. When required, if the Representative Form(s) is not received or is defective, on a Quality of Care Grievance, resulting in a dismissal of the Grievance, CalOptima Health will, but is not required to, investigate the Quality of Care Grievance. CalOptima Health is not required to notify the Enrollee of the outcome of the Grievance since the Grievance was not properly filed.

3. GARS staff shall notify the Quality Improvement (QI) Department of all Grievances involving Providers for use in the Recredentialing process and for other evaluation and tracking purposes.

4. CalOptima Health shall notify an Enrollee of the Grievance process available to the Enrollee through the QIO upon initial enrollment and annually thereafter, in the OneCare Member Handbook/Evidence of Coverage.

5. If an Enrollee files a Grievance regarding quality of care to the QIO, CalOptima Health shall cooperate with the QIO to resolve the Grievance and with any state Medicaid quality of care requirements for Medi-Cal covered benefits

H. Grievance Withdrawals

1. A Grieving Party may submit a written withdrawal request or verbal withdrawal for both written and verbal Grievances at any time before the decision is mailed by CalOptima Health.

2. CalOptima Health must clearly document in the system that the Enrollee does not want to proceed with Grievance procedures.

3. CalOptima Health shall, but is not required to, send a written confirmation of that withdrawal to the Enrollee within three (3) calendar days of receiving the withdrawal request.

4. If the Enrollee submits a Quality of Care Grievance verbally or in writing, but later decides to withdraw the Grievance, CalOptima Health is still required to investigate the Quality of Care Grievance; however, CalOptima Health is not required to notify the Enrollee of the outcome of the Grievance since they decided not to pursue it.

I. GARS shall refer a Grievance to the Office of Compliance, Provider Relations Department, or the Network Management Department if:

1. A CalOptima Health department, a Health Network, or a Provider, fails to submit requested information within the specified timeframe;

2. The Grievance is recurrent;

3. The Grievance remains unresolved; or

4. The Grievance necessitates disciplinary action.

J. Grievance Reporting

1. CalOptima Health shall categorize Grievances according to type.

2. GARS shall generate monthly reports of Grievances according to:

a. Resolution status;

b. Grievance type;

c. Provider; and

d. Number of calendar days to close the case.

3. GARS shall report quarterly aggregated data on Grievances to the Grievance and Appeal Resolution Committee for analysis and identification of trends and quality improvement opportunities.

4. CalOptima Health shall report aggregated Grievance data to state and federal agencies, as required. Such reports shall:

    a. Exclude personal, or Confidential, information with respect to any Enrollee; and

    b. Comply with formatting requirements specified by the state or federal agency. Information may include, but not limited to, the number and types of Grievances and resolutions.

6. Upon request, CalOptima Health shall provide aggregate Grievance data to an Enrollee. CalOptima Health shall maintain Confidentiality by excluding all Enrollee identification from such data. CalOptima Health may provide the following types of data to Enrollees:

    a. Number of Grievances per one thousand (1,000) Enrollees; and

    b. Number of Grievances involving quality of care in a specified time period.

7. GARS shall present to the Quality Improvement Health Equity Committee (QIHEC) on a quarterly basis any trends identified including those related to health inequities, implicit bias, and discrimination. GARS will update the QIHEC on any actions taken by the GARS Committee.

8. The written record of Grievances shall be reviewed periodically by CalOptima Health's Governing Board, the Member Advisory Committee (MAC), Provider Advisory Committee (PAC), and the Chief Operations Officer (COO) or designee, all who have the authority to require corrective action. The review and recommendations of such shall be thoroughly documented.

K. Complaint and Resolution Tracking

1. GARS will be responsible for receiving, responding to, and tracking complaints from the Complaint Tracking Module (CTM) in the Health Plan Management System administered by the Centers for Medicare and Medicaid Services (CMS).

L. Grievance Records

1. CalOptima Health shall maintain written records of each Grievance. Such records shall include at least the following information:

    a. Date of receipt;

    b. Enrollee's name;

    c. Name of the CalOptima Health employee assigned as the contact person;

    d. Description of the Grievance;

    e. Date of each review;

    f. Resolution of the Grievance;

    g. Date of resolution;

    h. Date the plan notified the enrollee of the resolution; and

i. Copies of all Medical Records, documents, evidence of coverage, and other relevant information CalOptima Health used to render its decision.

2. CalOptima Health shall maintain written records of each Grievance, including copies of Grievances and responses thereto, for a period of ten (10) years after the end of the fiscal year in which CalOptima Health's contract with Centers for Medicare & Medicaid Services terminates.

IV. ATTACHMENTS(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
C. CalOptima Health Policy GG.1353: CalAIM Enhanced Care Management Service Delivery
D. CalOptima Health Policy GG.1611: Potential Quality Issue Review Process
E. CalOptima Health Policy HH.1104: Complaints of Discrimination
F. CalOptima Health Policy MA.4004: Member Disenrollment
G. CalOptima Health Policy MA.6109: True Out-of-Pocket (TrOOP) Expenditures
H. CalOptima Health Policy MA.9015: Standard Integrated Appeals
I. CalOptima Health Policy MA.9004: Expedited Pre-Service Integrated Appeal
J. January 2022 CMS Final Rule
K. Medicare Managed Care Manual, Chapter 13
L. OneCare Member Handbook/Evidence of Coverage
M. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Effective July 19, 2024
N. Addendum to the Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans, Updated August 2022
O. Prescription Drug Benefit Manual, Chapter 18
P. Title 42, Code of Federal Regulations, §§ 422.111€(3), and 422.560, 422.561, 422.564(e)(2), 423.564(e)(2), 422.629-634, et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting	Action
05/05/2022	Regular Meeting of the CalOptima Board of Directors	Ratified Post-CEO Approval

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2005	MA.9002	Member Grievance Process	OneCare
Revised	07/01/2010	MA.9002	Member Grievance Process	OneCare
Revised	10/01/2012	MA.9002	Member Grievance Process	OneCare
Revised	11/01/2016	MA.9002	Member Grievance Process	OneCare
Revised	02/01/2018	MA.9002	Member Grievance Process	OneCare
Revised	04/01/2022	MA.9002	Member Grievance Process	OneCare

Action	Date	Policy	Policy Title	Program(s)
Revised	12/31/2022	MA.9002	Enrollee Grievance Process	OneCare
Revised	12/31/2024	MA.9002	Enrollee Grievance Process	OneCare

IX. GLOSSARY

Term	Definition
Acknowledgement Letter	A written statement acknowledging receipt of a Grievance.
Appeal	As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.
Authorized Representative	For purposes of this policy, an individual appointed by a Member, or a Member's parent, guardian, or other party, or authorized under State or other applicable law, to act on behalf of a Member involved in an Appeal or Grievance.
Complaint	Any expression of dissatisfaction to CalOptima Health, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may also involve CalOptima Health's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Confidential or Confidentiality	Means the property that data or information is not made available or disclosed to unauthorized persons or processes.
Coverage Determination	A decision made by the plan, or its delegated entity, on a request for coverage (payment or provision) of an item, service, or drug.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Enrollee	For purposes of this policy, the term "Enrollee" will be applied both synonymously and/or in lieu of the term "Member" to reflect regulatory and/or contractual language of the Centers for Medicare and Medicaid Services (CMS). An eligible individual who has elected a Medicare Advantage, Prescription Drug, or cost plan or health care prepayment plan (HCPP).
Governing Board	CalOptima Health's board of directors or a similar body, and/or its executive management, that has the authority to manage and direct CalOptima Health's affairs and activities, including, but not limited to, approving initiatives and establishing CalOptima Health's policies and procedures.
Grievance	An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.
Grievance Process	The process by which CalOptima Health and its Health Networks address and provide resolution to all Grievances.
Grievance Resolution Letter	A written statement explaining the disposition of a Grievance based on a review of the facts, relevant information, and documentation.

Term	Definition
Grieving Party	For purposes of this Policy, a Member, or a Member's Authorized Representative.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) 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.
Integrated Appeal	The procedures that deal with, or result from, adverse integrated organization determinations by an applicable integrated plan on the benefits both under Part C and under state Medicaid rules the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service. See 42 CFR § 422.561. Integrated appeals do not include appeals related to Part D benefits.
Integrated Grievance	A dispute or complaint that would be defined and covered, for grievances filed by an enrollee in non-applicable integrated plans, under § 422.564 or §§ 438.400 through 438.416 of this chapter. Integrated grievances do not include appeals procedures and QIO complaints, as described in § 422.564(b) and (c). An integrated grievance made by an enrollee in an applicable integrated plan is subject to the integrated grievance procedures in §§ 422.629 and 422.630. Integrated grievances do not include grievances related to Part D benefits.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	A beneficiary enrolled in the CalOptima Health OneCare program.
Organization Determination	Any determination made by OneCare with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider other than OneCare that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by OneCare. 3. OneCare's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by OneCare; 4. Discontinuation of a service if the Member believes that continuation of the service is medically necessary; and/or 5. OneCare's failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.

Term	Definition
Provider	Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Quality of Care Grievance	A type of Grievance that is related to whether the quality of covered services provided by CalOptima Health or provider meets professionally recognized standards of health care.
Quality Improvement Health Equity Committee (QIHEC)	A committee facilitated by CalOptima Health's medical director, or the medical director's designee, in collaboration with the Health Equity officer, that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.
Quality Improvement Organization (QIO)	An organization comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. A QIO reviews Complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers. A QIO also reviews continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in Skilled Nursing Facilities, Home Health Agencies, and Comprehensive Outpatient Rehabilitation Facilities.
Representative Form	For purposes of this Policy, a term used to collectively refer to an Appointment of Representative Form and/or equivalent written notice.
Threshold Languages	A threshold language is defined by CMS as the native language of a group who compromises five percent (5%) or more of the people served by the CMS Program.