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| Policy: | HH.1102 |
| Title: | **Member Grievance** |
| Department: | Grievance and Appeals Resolution Services |
| Section: | Not Applicable |
| *CEO Approval:* | */s/ Michael Hunn 09/05/2024* |
| Effective Date: | 07/01/2004 |
| Revised Date: | 09/01/2024 |
| Applicable to: | ☒ Medi-Cal<br>☐ OneCare<br>☐ PACE<br>☐ Administrative |

## I. PURPOSE

This policy defines the process by which CalOptima Health addresses and resolves Grievances from a Member, or a Provider or Authorized Representative acting on behalf of a Member and with the Member's written consent, in accordance with applicable statutory, regulatory, and contractual requirements.

## II. POLICY

A. CalOptima Health shall establish and maintain a Grievance Process pursuant to which a Member, or a Provider or Authorized Representative acting on behalf of a Member and with the Member's written consent, may submit a Grievance for review and Resolution either orally or in writing.

B. CalOptima Health's Grievance Process shall address the receipt, handling, and disposition of a Member's Grievance, in accordance with applicable statutory, regulatory, and contractual requirements.

C. A Member need not use the term "Grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance. If a Member declines to file a Grievance, the complaint shall still be categorized as a Grievance.

D. CalOptima Health shall assist a Member requiring assistance with filing a Grievance, including, but not limited to, a Member with limited English proficiency (LEP), disabilities, or cultural needs.

E. CalOptima Health shall ensure prompt review and investigation of a Grievance. A Health Network may participate in the review and investigation of a Grievance.

F. CalOptima Health shall process expedited requests timely in instances where a Provider indicates, or CalOptima Health determines, that the standard timeframe may seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

G. CalOptima Health shall ensure that the person making the final decision on the Grievance did not participate in any decisions related to the Grievance and he or she is not the subordinate of any person involved in the initial determination. If the Grievance is regarding the denial of an expedited

resolution of an Appeal or involves clinical issues, the person making the final decision shall also have the clinical expertise in treating a Member's condition or disease.

H. CalOptima Health shall refer all potential medical quality of care issues identified through the Grievance Process to the Quality Improvement Department for review.

I. CalOptima Health shall ensure that there is no discrimination against a Member, a Member's Authorized Representative, or Provider on the grounds that he or she filed a Grievance as required by federal and state nondiscrimination law and in accordance with CalOptima Health Policy HH.1104: Complaints of Discrimination.

J. CalOptima Health shall inform a Member of their right to file a Grievance through CalOptima Health at any time to express dissatisfaction about any matter other than an action resulting in a Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA), in accordance with the provisions of this Policy.

    1. A Member's Provider or Authorized Representative, acting on behalf of the Member with the Member's written consent, has the right to file a Grievance at any time.

K. CalOptima Health shall inform a Member, during the Grievance Process, of their right to request a State Hearing after the Appeal process, and of their right to Aid Paid Pending, in accordance with CalOptima Health Policies HH.1108: State Hearing Process and Procedures, GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization, and GG.1510: Member Appeal Process.

L. CalOptima Health shall give a Member a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the Grievance, evidence, testimony, facts, and law in support of the Grievance. CalOptima Health or a Health Network shall inform the Member of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited Grievances.

M. CalOptima Health shall consider all comments, documents, records, and other information submitted by the Member or the Member's Authorized Representative, regardless of whether such information was submitted or considered during the initial review.

N. CalOptima Health shall provide the opportunity, before and during the Grievance Process, to examine and or obtain a copy of the Member's case file, including the Medical Records, and any other relevant documents and records considered during the Grievance Process, upon request by the Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent. CalOptima Health shall provide records at no cost.

O. 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.

P. CalOptima Health and its Health Networks shall provide culturally and linguistically appropriate notices of the Grievance Process to Members, including language assistance taglines and a notice of non-discrimination in compliance with the requirements set forth by the Department of Health Care Services (DHCS), and in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

Q. A Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, may submit a request to appeal a decision not related to a utilization management decision with any supporting documentation to GARS. Such request shall be

considered a Non-Coverage Appeal and CalOptima Health shall process the request as a Grievance and in accordance with Section III.C. of this Policy.

R. Responsible staff

1. CalOptima Health's Chief Operating Officer (COO) shall have primary responsibility for:

   a. Maintenance of the Grievance Process;

   b. Review of the operations; and

   c. Identification of any emerging or systemic issues of Grievances and Appeals and/or patterns of improper service denials in the formulation of policy changes and procedural improvements to CalOptima Health's administration of the program.

2. CalOptima Health's Director of GARS shall have primary responsibility for the oversight of the Grievance Process.

## III. PROCEDURE

A. Assistance to Members

1. CalOptima Health and a Health Network shall make complaint forms and procedures for filing a Grievance available to facilities that provide Covered Services to Members.

2. CalOptima Health shall promptly provide complaint forms and procedures to a Member upon request.

3. CalOptima Health's Customer Service Department shall assist a Member with questions regarding the procedures for filing Grievances and shall triage Member calls and route Grievances to the GARS Department via its electronic system.

4. CalOptima Health shall ensure that Members accessing the Grievance system are given assistance in completing Grievance forms and other procedural steps, including but not limited to, providing auxiliary aids and services upon request, such as interpreter services and a toll-free number with TTY/TDD and interpreter capability.

B. Grievance Process

1. A Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, may file a Grievance:

   a. With CalOptima Health's Customer Service Department, by telephone, or in person; or

   b. With CalOptima Health GARS, by facsimile, in writing, or through the CalOptima Health website at www.CalOptima.org.

   c. CalOptima Health shall provide language assistance, by CalOptima Health staff for Threshold Languages and language line interpretation services, as needed, to register and resolve Grievances in all other languages.

   d. In the event an oral Grievance is received, CalOptima Health will process the Grievance regardless of whether a signed, written Grievance is subsequently received from the Member.

e. CalOptima Health shall process Exempt Grievances in accordance with CalOptima Health Policy DD.2013: Customer Service Grievance Process.

f. CalOptima Health shall process a Grievance for discrimination as required by federal and State nondiscrimination law and in accordance with CalOptima Health Policy HH.1104: Complaints of Discrimination.

2. GARS shall:

a. Date stamp and document the substance of the Grievance, and any action taken, including but not limited to the Member's previous complaint history and follow-up activities associated with the complaint, in the GARS database, verifying demographics and network affiliation.

b. Determine the category of Grievance, including but not limited to the following categories: quality of care, quality of service, access to care, and other, based on the Grievance. Assign type and subtype descriptors, the responsible staff, and documentation of issue(s).

c. Send the Member an Acknowledgment Letter within five (5) calendar days after receipt of a Grievance, indicating receipt of the Grievance, the date of receipt of the Grievance, and providing the name, telephone number and address of the GARS staff member whom the Member may contact regarding the Grievance, and provide the Member with an estimated completion date of Resolution.

d. Triage and investigate the Grievance, and, as necessary, consult with the CalOptima Health department or Health Network responsible for the services or operations that are the subject of the Grievance.

e. Refer all Grievances related to potential medical quality of care issues to the Quality Improvement (QI) Department for immediate review by CalOptima Health's Chief Medical Officer (CMO) or their Designee and any action deemed necessary under the quality review process in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process.

f. Review and immediately process all Grievances that may seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function, on an expedited basis and issue the decision within seventy-two (72) hours of receipt. CalOptima Health shall provide oral notice of the Resolution of an expedited Grievance as required in the CalOptima Health contract with DHCS.

g. Escalate the Grievance for review of the factual findings, proposed Resolution, and any other relevant information, in accordance with CalOptima Health Policy HH.1109: Complaint Decision Matrix and shall issue a decision with respect to the Grievance.

h. Send the Member, or Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, a Grievance Resolution Letter, not to exceed thirty (30) calendar days from the date CalOptima Health receives the oral or written Grievance.

i. Ensure that Members or a Member's Authorized Representative have equal access to, and can fully participate in, the Grievance process by providing assistance to Members, or a Member's Authorized Representative, with disabilities, limited English proficiency, vision

disorders, or other communicative impairments by providing the following services in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services:

i. Translate Grievance correspondence into Threshold Languages, and offer oral interpretation for Grievance correspondence for all other languages;

ii. Provide an interpreter, or auxiliary aides, for assistance in the Grievance Process; and

iii. Alternative formats (as set forth in All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, And Language Assistance Services)

3. The Grievance Resolution Letter shall describe the Grievance, and provide a clear and concise explanation of the reasons for the decision, including, but not limited to:

   a. Summary of the Member's Grievance;

   b. The investigation made in the review process, including any referrals to the Quality Improvement Department for medical quality of care review;

   c. When possible, the outcome of the review;

   d. Alternative resources or references, when applicable; and

   e. The Member's right to Appeal within sixty (60) days, as appropriate.

4. GARS staff shall close the case in the GARS database by documenting the disposition of the Grievance, reviewing entity(ies), decision and any additional action taken (if any), include a copy of the Grievance Resolution Letter and document any oral notification provided to the Member and save the electronic file.

5. Grievances for Pharmacy Services

   a. CalOptima Health shall process Grievances for pharmacy services rendered or requested before the implementation of Medi-Cal Rx, in accordance with this Policy.

   b. For Grievances received in writing in the GARS Department for pharmacy services that are part of the Medi-Cal Rx transition, CalOptima Health shall refer such Grievances received to the Medi-Cal Rx Customer Service Center within three (3) calendar days pursuant to the Medi-Cal Rx transition requirements.

6. Grievances Related to Privacy Rights

   a. CalOptima Health shall inform a Member of their right to file a Grievance with CalOptima Health or with the Secretary of Health and Human Services regarding violations of their privacy rights, in accordance with CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII.

C. Non-Coverage Appeals

1. A Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, may submit a request to appeal a decision not related to a utilization management decision with any supporting documentation to GARS within sixty (60)

calendar days of the date of the Non-Coverage Decision Resolution Letter. This type of Grievance is considered a Non-Coverage Appeal and is separate from the Appeal process in CalOptima Health Policy GG.1510: Member Appeal Process.

2. A Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, may file the Non-Coverage Appeal with CalOptima Health's Customer Service Department by telephone or in person, or with GARS via facsimile, in writing or through the CalOptima Health Website at www.CalOptima.org.

3. CalOptima Health shall provide language assistance by CalOptima Health staff for Threshold Languages and language line interpretation services, as needed, to register and resolve Grievances in all other languages.

4. The CMO or their Designee not involved in the initial review shall conduct the review of the decision.

5. Upon receipt of the Non-Coverage Appeal GARS shall:

    a. Date stamp and document the substance of the Non-Coverage Appeal, and any action taken, into its electronic system, verifying demographics and network affiliation;

    b. Determine the category of the Non-Coverage Appeal based on the Grievance, assign type and subtype descriptors, the responsible staff, and documentation of issue(s);

    c. Send a Member an Acknowledgment Letter within five (5) calendar days after receipt of a Non-Coverage Appeal, indicating receipt of the Grievance and identifying a GARS staff member whom the Member may contact regarding the Non-Coverage Appeal;

    d. Triage and investigate the Non-Coverage Appeals and, as necessary, consult with the CalOptima Health department or Health Network responsible for the services or operations that are the subject of the Complaint;

    e. Refer all Non-Coverage Appeals related to potential quality of care issues to the QI Department for review by the CalOptima Health Chief CMO or their Designee and any action deemed necessary under the quality review process;

    f. Review and immediately process all Non-Coverage Appeals involving an imminent and serious threat to the health of a Member including, but not limited to, severe pain or potential loss of life, limb, or major bodily function, on an expedited basis for effectuation of the decision within seventy-two (72) hours of receipt;

    g. Notify the Member of the Non-Coverage Appeal decision in writing within thirty (30) calendar days of the receipt of the Grievance and include the next level Appeal rights attachments including the right to a State Hearing.

        i. CalOptima Health shall provide language assistance, by CalOptima Health staff for Threshold Languages and language line interpretation services, as needed to register and resolve Grievances in all other languages.

        ii. For Grievances appealing Non-Coverage Appeal decisions, including but not limited to requests to be in CalOptima Health Direct - Administrative, and for access to out-of-network Providers or change of Health Networks, the resolution letter shall include:

            a) Summary of the Member's Non-Coverage Appeal;

b) Description of actions taken to review the request;

c) Date and name of position of staff involved in the review; and

d) Date of the issuance of the decision.

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

7. GARS staff shall close the case in its electronic system by documenting the disposition of the Non-Coverage Appeal, reviewing entity(ies), decision and any additional action taken (if any), include a copy of the Resolution Letter and document any oral notification provided to the Member, and resolution date.

D. Notices, Records and Reports

1. Upon enrollment, and annually thereafter, CalOptima Health shall inform a Member, in writing, of the locations for filing a Grievance, telephone numbers where a Grievance may be submitted, and related procedures regarding the Grievance Process. CalOptima Health shall provide these notices in Threshold Languages, as required by CalOptima Health's contract with DHCS.

2. CalOptima Health shall maintain and make accessible to DHCS, and, upon request, have available for the Centers for Medicare & Medicaid Services, written records of each Grievance, including copies of Grievance records of any sub-contracting entity delegated the responsibility to maintain and resolve Grievances. The records shall include the date and time of receipt, Member's name, description of the complaint or problem, names of the CalOptima Health staff who received the Grievance and who is designated as the contact person, description of the action taken to investigate/resolve the problem, resolution proposed by GARS or the medical professional responsible for making utilization management decision, the name of the CalOptima Health provider or staff responsible for resolving the Grievance, the date of notification to the Member of resolution, and all Grievance Resolution Letters. CalOptima Health shall maintain the written records, for a minimum of ten (10) years from the final date of the contract period for CalOptima Health's contract with the DHCS or from the date of completion of any audit, whichever is later.

3. CalOptima Health shall continually evaluate and analyze Grievance data to identify systemic patterns of improper services denials and other trends impacting health care delivery to Members.

4. On a quarterly basis, CalOptima Health shall submit all recorded Member Grievances related to access to care, quality of care and denial of services to the Quality Improvement Committee (QIC) to review and take appropriate action to remedy any problems identified in such reviews.

5. CalOptima Health shall submit a monthly report of complete, accurate, reasonable, and timely aggregated Grievance data within ten (10) calendar days following the end of each month or as otherwise agreed upon by DHCS, and in the format specified with DHCS, in accordance with this Policy and CalOptima Health Policy AA.1270: Certification of Document and Data Submissions.

6. CalOptima Health shall submit on a quarterly basis aggregate and detailed Grievance data to the Quality Assurance Committee.

7. CalOptima Health shall submit a report of Grievances related to a Member's receiving Long Term Care Services, as required by DHCS. CalOptima Health shall not be responsible for reporting Grievances or Resolutions related to a Member's receiving In-Home Supportive Services (IHSS) or Multipurpose Senior Services Program (MSSP) if the Grievance was reported to the County of Orange or MSSP site.

8. CalOptima Health shall establish and maintain a system of aging Grievances that are pending and unresolved for thirty (30) calendar days or more and include a brief explanation of the reasons for each pending and unresolved Grievance.

9. 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.

10. The written record of Grievances shall be reviewed periodically by CalOptima Health's Governing Board, the Member Advisory Committee (MAC), and 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.

## IV. ATTACHMENT(S)

Not Applicable

## V. REFERENCE(S)

A. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy AA.1270: Certification of Document and Data Submissions
C. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
D. CalOptima Health Policy DD.2013: Customer Service Grievance Process
E. CalOptima Health Policy GG.1353: CalAIM Enhanced Care Management Service Delivery
F. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
G. CalOptima Health Policy GG.1510: Member Appeal Process
H. CalOptima Health Policy GG.1611: Potential Quality Issue Review Process
I. CalOptima Health Policy HH.1104: Complaints of Discrimination
J. CalOptima Health Policy HH.1108: State Hearings Process and Procedures
K. CalOptima Health Policy HH.1109: Complaint Decision Matrix
L. CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-017: Requirements for Reporting Managed Care Program Data (Supersedes APLs 14-013 (Revised) and 14-012)
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-022: COVID-19 Vaccine Administration (Revised 10/06/2022)
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services (Supersedes APL 17-011 and Policy Letters 99-003 and 99-004) (Revised 05/24/2023)
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates (Supersedes APL 17-006) (Revised 08/31/2022)
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-002: Alternative Format Selection for Members With Visual Impairments

R. 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) (Revised 12/30/2022)
S. Standards and Guidelines for the Accreditation of Health Plans
T. Title 22, California Code of Regulations (C.C.R.), § 53858
U. Title 22, California Code of Regulations (C.C.R.), § 53858 (e)
V. Title 28, California Code of Regulations (C.C.R.), §§ 1300.68 (except Subdivision 1300.68(c), (g), and (h)) and 1300.68.01 (except Subdivision 1300.68.01(b) and (c))
W. Title 42, Code of Federal Regulations (C.F.R.), § 438.228
X. Title 42, Code of Federal Regulations (C.F.R.), § 438.3(u)
Y. Title 42, Code of Federal Regulations (C.F.R.), §§ 438.400 - 424

## VI. REGULATORY AGENCY APPROVAL(S)

| Date | Regulatory Agency | Response |
|---|---|---|
| 06/29/2015 | Department of Health Care Services (DHCS) | Approved as Submitted |
| 12/10/2015 | Department of Health Care Services (DHCS) | Approved as Submitted |
| 06/21/2017 | Department of Health Care Services (DHCS) | Approved as Submitted |
| 07/26/2021 | Department of Health Care Services (DHCS) | Approved as Submitted |
| 04/06/2022 | Department of Health Care Services (DHCS) | Approved as Submitted - AIR |
| 07/01/2022 | Department of Health Care Services (DHCS) | Approved as Submitted |
| 01/27/2023 | Department of Health Care Services (DHCS) | Approved as Submitted |
| 07/28/2023 | Department of Health Care Services (DHCS) | File & Use |
| 06/20/2024 | Department of Health Care Services (DHCS) | File & Use |

## VII. BOARD ACTION(S)

| Date | Meeting |
|---|---|
| 03/07/2019 | Regular Meeting of the CalOptima Board of Directors |
| 05/05/2022 | Regular Meeting of the CalOptima Board of Directors |

## VIII. REVISION HISTORY

| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Effective | 07/01/2004 | HH.1102 | CalOptima Member Complaint | Medi-Cal |
| Revised | 12/01/2005 | HH.1102 | CalOptima Member Complaint | Medi-Cal |
| Revised | 01/01/2007 | HH.1102 | CalOptima Member Complaint | Medi-Cal |
| Revised | 01/01/2009 | HH.1102 | CalOptima Member Complaint | Medi-Cal |
| Revised | 06/01/2009 | HH.1102 | CalOptima Member Complaint | Medi-Cal |
| Revised | 01/01/2011 | HH.1102 | CalOptima Member Complaint | Medi-Cal |
| Revised | 01/01/2013 | HH.1102 | CalOptima Member Complaint | Medi-Cal |
| Revised | 01/01/2014 | HH.1102 | CalOptima Member Complaint | Medi-Cal |
| Revised | 06/01/2014 | HH.1102 | CalOptima Member Complaint | Medi-Cal |
| Revised | 06/01/2015 | HH.1102 | CalOptima Member Complaint | Medi-Cal |
| Revised | 10/01/2015 | HH.1102 | CalOptima Member Complaint | Medi-Cal |
| Revised | 06/01/2016 | HH.1102 | CalOptima Member Complaint | Medi-Cal |
| Revised | 02/01/2017 | HH.1102 | CalOptima Member Complaint | Medi-Cal |
| Revised | 07/01/2017 | HH.1102 | CalOptima Member Complaint | Medi-Cal |

| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Revised | 03/07/2019 | HH.1102 | Member Grievance | Medi-Cal |
| Revised | 04/01/2021 | HH.1102 | Member Grievance | Medi-Cal |
| Revised | 05/05/2022 | HH.1102 | Member Grievance | Medi-Cal |
| Revised | 06/01/2022 | HH.1102 | Member Grievance | Medi-Cal |
| Revised | 03/01/2023 | HH.1102 | Member Grievance | Medi-Cal |
| Revised | 07/01/2023 | HH.1102 | Member Grievance | Medi-Cal |
| Revised | 06/01/2024 | HH.1102 | Member Grievance | Medi-Cal |
| Revised | 09/01/2024 | HH.1102 | Member Grievance | Medi-Cal |

## IX. GLOSSARY

| Term | Definition |
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| Acknowledgment Letter | A written statement acknowledging receipt of a Grievance. |
| Adverse Benefit Determination | Any of the following actions taken by CalOptima Health or a Health Network:<br><br>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.<br>2. The reduction, suspension, or termination of a previously authorized service.<br>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.<br>4. The failure to provide services in a timely manner.<br>5. The failure to act within the required timeframes for standard resolution of grievances and appeals.<br>6. For a resident of a rural area with only one managed care plan, the denial of the Member’s request to obtain services outside the network.<br>7. The denial of a Member’s request to dispute financial liability. |
| Aid Paid Pending | Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a Notice of Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service. |
| Appeal | A review by CalOptima Health of an Adverse Benefit Determination, which includes one of the following actions:<br><br>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;<br>2. A reduction, suspension, or termination of a previously authorized service;<br>3. A denial, in whole or in part, of payment for a service;<br>4. Failure to provide services in a timely manner; or<br>5. Failure to act within the timeframes provided in 42 CFR 438.408(b). |
| 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. |
| Covered Services | Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.<br><br>Covered Services do not include: |

| Term | Definition |
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| | 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services;<br>2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services;<br>3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services);<br>4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services);<br>5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members);<br>6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis);<br>7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services;<br>8. Prayer or spiritual healing as specified in 22 CCR section 51312;<br>9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services);<br>10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH);<br>11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services;<br>12. State Supported Services;<br>13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR |

| Term | Definition |
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| | sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005;<br>14. Childhood lead poisoning case management provided by county health departments;<br>15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living;<br>16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and<br>17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. |
| 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. |
| Expedited Appeal | Considered urgent if the Member's medical condition involves an imminent and serious threat to the mental or physical health of the Member, including but not limited to severe pain, potential loss of life, limb or major bodily function, or lack of timeliness that could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function |
| 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 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. |
| 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. |
| 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. |
| In-Home Supportive Services (IHSS) | Services provided to Members by the County in accordance with the requirements set forth in Welfare & Institutions Code Section 14186.1(c)(1), and Article 7 of the Welfare & Institutions Code, commencing with Section 12300 of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956. |
| Long Term Care (LTC) | Care provided in a skilled nursing facility and sub-acute care services that lasts longer than 60 days. |

| Term | Definition |
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| Medical Record | The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications. |
| 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. |
| Multipurpose Senior Service Program (MSSP) | The Waiver program that provides social and health care management to a Member who is 65 years or older and meets a nursing facility level of care as an alternative to nursing facility placement in order to allow the Member to remain in their home, pursuant to the Medi-Cal 2020 Waiver. |
| Non-Coverage Appeal | Grievances about decisions that are not related to utilization management decisions. |
| 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. |
| State Hearing | A hearing with an Administrative Law Judge to resolve a Member's dispute about an action taken by CalOptima Health, its Network Providers, Subcontractors, or Downstream Subcontractors. |
| 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. |