Policy:	CMC.9002
Title:	**Member Grievance Process**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 08/18/2022*
Effective Date:	07/01/2015
Revised Date:	05/01/2022
Applicable to:	☐ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This Policy defines the process by which CalOptima shall address and resolve a OneCare Connect Member's Grievance, in accordance with applicable statutory, regulatory, and contractual requirements of the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS).

II. POLICY

A. CalOptima shall establish and maintain a process that addresses the receipt, handling, and disposition of Grievances, in accordance with applicable statutes, regulations, contractual requirements, and this Policy.

B. Grievance and Appeals Resolution Services (GARS) staff shall review and investigate Grievances.

C. GARS staff shall be responsible to adjudicate all Grievances that are the responsibility of CalOptima.

D. 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 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. A Member's involuntary disenrollment initiated by CalOptima;

   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 via phone;

   f. Interpersonal aspects of care;

g. CalOptima's Appeals process;

h. CalOptima's decision not to expedite an Appeal request;

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

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

k. Calculation of True Out-of-Pocket (TrOOP) costs.

E. A Grieving Party may file a Grievance directly with CalOptima or the OneCare Connect Ombudsman Program for complaints related to Medi-Cal and Medicare covered benefits and services, or directly with 1-800-MEDICARE for Medicare covered benefits and services.

F. CalOptima shall establish and maintain a process pursuant to which a Grieving Party may submit a Grievance for review and resolution either orally or in writing.

1. A Grieving Party, may file a Grievance regarding Medi-Cal and Medicare covered benefits and services at any time by calling or writing to CalOptima.

G. CalOptima must display a link to the electronic Grievance form on the Medicare.gov Internet Web site on CalOptima's main web page pursuant to 42 C.F.R. §422.504 (a)(15)(ii).

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

I. CalOptima shall have a system in place for addressing Member Grievances, including Grievances regarding reasonable accommodations and access to services under the Americans with Disabilities Act (ADA).

J. CalOptima shall maintain written records of all Grievance activities, and notify Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) of all internal Grievances, and meet the standards set forth in contractual requirements.

K. If a Grievance involves two or more issues at the same time, CalOptima shall process each issue separately and simultaneously under the appropriate process.

L. Grievance and Appeals Resolution Services (GARS) staff shall review and investigate Grievances.

1. Decision makers for Grievances should not have been involved in previous levels of review or decision-making, nor were a subordinate of any such person. Additionally, decision makers must be health care professionals with clinical expertise in treating the Member's condition or disease if any of the following apply:

a. A Grievance regarding denial of expedited resolutions of an Appeal; or

b. Any Grievance involving clinical issues.

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

N. Except as provided in this Policy, CalOptima shall respond to a Grievance within thirty (30) calendar days after receipt of the Grievance.

O. CalOptima shall respond to an Expedited Grievance within twenty-four (24) hours after receipt of such Expedited Grievance.

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

1. CalOptima shall refer all medical quality of care issues identified through the Grievance process to the Quality Improvement Department for review in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process.

R. CalOptima shall 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 Policy CMC.4002: Cultural and Linguistic Services:

1. Translation of forms and responses;

2. Interpretation services;

3. Telephone relay systems;

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

5. Other auxiliary aids or services; and

6. Other reasonable accommodations, as appropriate.

S. Disputes on rewards and incentives shall be treated as a Grievance. When a Member brings forth a dispute pertaining to a reward or the reward program, such dispute shall be addressed and resolved under the Grievance process, in accordance with this Policy.

T. Member Notice

1. CalOptima shall notify a Member of the Grievance process, as well as the right to file a Grievance directly with OneCare Connect Ombudsman Program for Medi-Cal or Medicare covered benefits and services, or directly with 1-800-Medicare for Medicare covered benefits and services, upon initial enrollment and annually thereafter in the OneCare Connect Member Handbook;

2. The Customer Service Department shall inform a Member of the Grievance process upon the Member's involuntary disenrollment from OneCare Connect and in accordance with CalOptima Policy CMC.4004 Member Disenrollment;

3. CalOptima's Utilization Management Department, or the Member's Health Network, shall notify a Member of the Grievance process, and the right to file a Grievance directly with OneCare Connect Ombudsman Program or Medicare, upon denial of the Member's request for an expedited review; and

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

U. Upon request from a Member or Provider, GARS staff shall provide:

1. Information on how a Member may file a Grievance directly with CalOptima, OneCare Connect Ombudsman Program, or Medicare;

2. The OneCare Connect Member Request, Appeal and Complaint Form to a Member or a Provider; and

3. Assistance to a Member who wishes to file a Grievance.

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

W. CalOptima shall maintain Member confidentiality throughout the Grievance process.

X. During the Multipurpose Senior Services Program (MSSP) Waiver transition period for Members who are also receiving Waiver Services, referred to as Waiver Participants who are also Plan Members (WPPMs), CalOptima shall keep records of resolutions of a WPPM's Complaints that are received internally and from MSSP providers, for any Complaints made on Waiver Services.

1. The WPPM may submit Grievance to the MSSP Provider either orally, or in writing.

2. The MSSP Provider's Grievance process shall include receiving, acknowledging, responding to, and tracking WPPM Complaints using an internal tracking system and in compliance with the Member Grievance System.

3. During the investigation of the Grievance, all Waiver Services shall remain in effect.

Y. CalOptima shall track and report to DHCS the number and types of Complaints, Grievances, Appeals, and resolutions in accordance with contractual reporting requirements.

Z. CalOptima Customer Service Department shall track Member inquiries in accordance with CalOptima Policy CMC.4007: Member Disclosures.

III. PROCEDURE

A. Parties to a Grievance

1. A Member or an individual appointed by the Member (e.g., relative, friend, advocate, attorney) acting as the Member's Authorized Representative may file a Grievance. If an Authorized Representative files a Grievance involving Medicare covered services, 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 Member and the Member's Authorized Representative, except if an attorney acts as the Member'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 Member only.

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

    a. Such Authorized Representative 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 paper supporting his or her status under state law (a Representative Form is not required).

3. A Grieving Party for Grievances involving Medi-Cal covered services, may file an Authorization for Release of Protected Health Information (PHI) form, in lieu of any type of Representative Form.

B. Request for a Grievance

1. A Grieving Party may file a Grievance;

    a. Verbally, by telephone, or in-person, with CalOptima's Customer Service Department;

    b. Directly with OneCare Connect Ombudsman Program for Medi-Cal or Medicare covered benefits and services;

    c. Directly with 1-800-MEDICARE for Medicare covered benefits and services; or

    d. In writing to the GARS Department.

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

    a. CalOptima 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, 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'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's website.

3. Expedited Grievance for Medicare covered services

    a. A Grieving Party may request an expedited Grievance if:

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

ii. CalOptima determines that a Member's request for an expedited Appeal fails to meet expedited criteria, in accordance with CalOptima Policy CMC.9004: Expedited Appeal, and decides to process the Member's request as a standard Appeal, in accordance with CalOptima Policy CMC.9003: Standard Appeal; or

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

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

C. Grievance Timeframe

1. Standard Grievance

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

i. If CalOptima determines that an extension will be taken, GARS staff shall promptly notify the Member, in writing, and explain the reason for the extension and the Member's right to request an expedited Grievance if the Member disagrees with the time extension.

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

2. Expedited Grievance

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

b. The expedited Grievance processing timeframe begins when the appropriate CalOptima 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 Member to obtain any missing information or evidence concerning the Grievance and enter such information in the database.

2. Except in the case of an Expedited Grievance, GARS staff shall send an acknowledgement letter to the Member after CalOptima's receipt of the Grievance. The 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 any type of Representative Form or Authorization for Release of PHI form documentation is not received by the thirty (30) calendar day resolution or fourteen (14) calendar day extension standard timeframe, or the twenty-four (24) hour expedited timeframe, CalOptima will not 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 Member's Authorized Representative.

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

    c. If CalOptima does not receive documentation of the requestor's status as the Member's Authorized Representative after retrieval attempts, CalOptima shall dismiss the Grievance and notify the Member, in writing, that the request for Grievance shall be dismissed due to lack of the required documentation to process the Grievance.

4. If CalOptima determines that it misclassified a Member's Grievance as an Appeal, it shall notify the Member, in writing, of the misclassified Grievance, and shall process the reclassified Grievance through the Grievance process. CalOptima shall consider the date or receipt of the original request as the date of receipt of the Grievance and not as the date the misclassification was discovered.

5. If a CalOptima employee receives a Member's request to file a complaint related to long-term services and support (LTSS) for which OneCare Connect is not responsible, CalOptima will assist the Member by providing information on how to contact their local social service agency. For In Home Support Services (IHSS) complaints, the Member will be instructed to request to speak to their assigned IHSS Social Worker at 1-714-825-3000.

6. CalOptima shall process Exempt Grievances in accordance with CalOptima Policy DD.2013: Exempt Grievance Process.

E. Grievance Investigation

1. The GARS staff shall forward a Member Complaint Referral to the responsible department as applicable, Health Network or Provider 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 responsible department's, Health Network's or Provider's investigation and resolution of a Grievance, the GARS Director, or designee, shall review the Grievance for completion and appropriate designation.

F. Grievance Resolution

1. CalOptima shall respond to a Grievance related to quality of care in writing, regardless if the Grievance is filed orally or in writing. The written response shall include a description of the Member's right to file a written Grievance with the Quality Improvement Organization.

2. CalOptima may consult with its legal counsel prior to responding to a Member's Grievance.

3. CalOptima shall take immediate action to implement the decision in accordance with the Grievance Resolution Letter approved by CMS and DHCS.

    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 upon 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 upon receipt of such request, and provide the Grieving Party, in writing, a Grievance Resolution Letter, no later than three (3) calendar days of the verbal notification.

    c. If a Grievance (including Quality of Care Grievances) was filed by the Member's Authorized Representative, the Authorized Representative must be notified in lieu of the Member. GARS staff shall provide notice to both the Authorized Representative and the Member.

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

    a. The problem is resolved; and

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

    c. The Member 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, 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 Policy: GG.1611: Potential Quality Issue Review Process.

2. CalOptima 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 Member's right to file a written Grievance with the QIO.

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 shall notify a Member of the Grievance process available to the Member through the QIO upon initial enrollment and annually thereafter, in the OneCare Connect Member Handbook/Evidence of Coverage.

5. If a Member files a Grievance regarding quality of care to the QIO, CalOptima shall cooperate with the QIO to resolve the Grievance.

H. Grievance Withdrawals

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

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

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

4. If the Member submits a Quality of Care Grievance verbally or in writing, but later decides to withdraw the Grievance, CalOptima is still required to investigate the Quality of Care Grievance; however, CalOptima is not required to notify the Member 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, or the Health Network Provider Relations Department if:

1. A CalOptima 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 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 days to close the case.

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

4. CalOptima shall report aggregated Grievance data to state and federal agencies as required.

5. Such reports shall:

    a. Exclude personal or confidential information with respect to any Member; 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 shall provide aggregate Grievance data to a Member. CalOptima shall maintain confidentiality by excluding all Member identification from such data. CalOptima may provide the following types of data to Members:

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

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

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 (HPMS) administered by the Centers for Medicare and Medicaid Services (CMS).

L. Grievance Records

1. CalOptima shall maintain written records of all Grievance activities and notify CMS and DHCS of all Grievances. Such records shall include at least the following information:

    a. Date of receipt;

    b. Member's name;

    c. Name of the CalOptima employee who recorded the Grievance;

    d. Description of the reason for the Grievance;

    e. The date of each review or, if applicable, review meeting;

    f. Resolution information including date or resolution;

    g. The Grievance record must be accessible to CMS and DHCS upon request; and

    h. Copy of all Medical Records, documents, evidence of coverage, and other relevant information CalOptima used to render its decision.

2. CalOptima 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's contract with state and federal agencies terminates.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect (CMC)
C. CalOptima Policy CMC.4002: Cultural and Linguistic Services
D. CalOptima Policy CMC.4007: Member Disclosures
E. CalOptima Policy CMC.9003: Standard Appeal
F. CalOptima Policy CMC.9004: Expedited Appeal
G. CalOptima Policy DD.2013: Exempt Grievance Process
H. CalOptima Policy GG.1611: Potential Quality Issue Review Process
CalOptima Policy HH.1104: Complaint of Discrimination
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-002: Multipurpose Senior Services Program Complaint, Grievance, Appeal, and State Hearing Responsibilities in Coordinated Care Initiative Counties, issued January 22, 2015Department of Health Care Services (DHCS) All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-002: Alternative Format Selection For Members With Visual Impairments
K. Medicare Managed Care Manual, Chapter 13
L. OneCare Connect Member Handbook
M. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
N. Title 42, Code of Federal Regulations (C.F.R.), §422.560 et. seq., 438.402, 406, 408, and 416
O. California Code, Welfare and Institutions Code (WIC) section 14182.17(e)(4)(E)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/01/2022	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2015	CMC.9002	Member Grievance Process	OneCare Connect
Revised	11/01/2015	CMC.9002	Member Grievance Process	OneCare Connect
Revised	08/01/2016	CMC.9002	Member Grievance Process	OneCare Connect
Revised	05/01/2022	CMC.9002	Member Grievance Process	OneCare Connect

IX. GLOSSARY

Term	Definition
Appeal	In general, a Member's actions, both internal and external to CalOptima requesting review of CalOptima's denial, reduction or termination of benefits or services, from CalOptima. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima of an Adverse Benefit Determination.
Authorized Representative	An individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the Appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423, Subpart M, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request or in dealing with any of the levels of the Appeals process, subject to the rules described in Part 422, Subpart M.
Complaint	A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
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.
Grievance	Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights). Also called a "Complaint."
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 to provide Covered Services to Members assigned to that Health Network.
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 OneCare Connect program.
Organization Determination	Any determination made by OneCare Connect 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 Connect 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 Connect. 3. OneCare Connect'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 Connect; 4. Discontinuation of a service if the Member believes that continuation of the service is medically necessary; and 5. OneCare Connect'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.
OneCare Connect Ombudsman Program	The independent contractor responsible for assisting and resolving issues that Members may encounter with Cal MediConnect Plans.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes Covered Services.
Quality of Care Grievance	A type of Grievance that is related to whether the quality of covered services provided by CalOptima, or provider meets professionally recognized standards of health care.
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.
Reason Code	The alpha/numeric codes used to identify each issue within a Member's Appeal or Grievance.
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	As specified in annual guidance to CalOptima on specific translation requirements for their service areas.
Waiver Services	Multipurpose Senior Service Program (MSSP) services under the MSSP Waiver.