Policy:	HH.1108
Title:	**State Hearing Process and Procedures**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 09/12/2024*
Effective Date:	07/01/2007
Revised Date:	09/01/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines CalOptima Health's process, role, and responsibilities in ensuring a Member's right to access the State Hearing process.

II. POLICY

A. A Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, has a due process right to request a State Hearing when a claim for medical assistance is delayed, modified, denied, or discontinued and/or not acted upon with reasonable promptness.

B. Once the CalOptima Health-level Appeal Process has been exhausted, a Member, or a Provider or Authorized Representative acting on behalf of a Member and with the Member's written consent, may request a State Hearing:

1. After receiving a Notice of Resolution (NAR) stating that CalOptima Health's action has been upheld, and the request is made no later than one hundred and twenty (120) calendar days from the date of the NAR; or

2. If the Member is deemed to have exhausted CalOptima Health's internal Appeal Process due to CalOptima Health's failure to meet or respond to the thirty (30) calendar day resolution timeline or comply with the notice requirements in accordance with Title 42, Code of Federal Regulations (CFR) Section 438.10. In cases of Deemed Exhaustion, CalOptima Health shall not request a dismissal of a Fair Hearing based on a failure to exhaust CalOptima Health's internal Appeal Process.

C. CalOptima Health is not involved in the Medi-Cal eligibility process and shall not participate in State Hearings related to eligibility determinations. However, as the Medi-Cal managed care plan in Orange County, CalOptima Health shall participate in State Hearings that address medical service denials to Members.

D. CalOptima Health shall provide a Member with a thorough explanation of the right to request a State Hearing, and shall assist the Member, upon request, in filing his or her request for a State

Hearing. Upon request, CalOptima Health shall provide any and all information that can be of assistance to the Member in preparing for the State Hearing, including all documents, guidelines and clinical criteria CalOptima Health relied on for the initial denial and anything the CalOptima Health considered during the internal CalOptima Health Appeal Process, as well as both regulations and evidence, which might be favorable to the Member's case.

E. A Member shall file a request for a State Hearing with the Department of Social Services (DSS) within one hundred and twenty (120) calendar days after the date of the NAR or Appeal resolution timeframe has exhausted.

F. CalOptima Health shall grant Aid Paid Pending while the State Hearing is pending in accordance with Section III.C. of this Policy.

G. CalOptima Health shall not unlawfully discriminate against a Member for requesting a State Hearing.

H. The parties to a State Hearing include CalOptima Health, with the assistance of the Member's Health Network, as well as the Member and the Member's Authorized Representative or representative of a deceased Member's estate. CalOptima Health shall act on its own behalf as the public agency that administers the Medi-Cal program in Orange County, and may represent its Health Networks, if no other representation is provided. Whenever the issue pertains to a Health Network's action or inaction, representatives from the involved Health Network are requested to attend the hearing.

I. CalOptima Health shall notify Members of the expected State Fair Hearing decision timelines:

   1. Standard State Hearing: The state must issue a final decision within ninety (90) calendar days of the date of the State Hearing request.

   2. Expedited State Hearing: The state must issue a final decision within three (3) business days of the date of the Expedited Hearing request.

J. CalOptima Health shall maintain all State Hearings case files involving a Member for at least ten (10) years after the resolution of the Appeal.

K. CalOptima Health shall monitor the number, type, and resolution of State Hearings, and utilize this information to improve its and its Health Networks' provision of services.

III. PROCEDURE

A. CalOptima Health shall communicate the Appeal Process and the Member's statutory right to a State Hearing to a Member in writing, in accordance with CalOptima Health Policy GG.1510: Member Appeal Process. This disclosure shall be included in the CalOptima Health Member Handbook, in accordance with CalOptima Health Policy DD.2005: Member-Informing Materials Requirements and an explanation of the right to request a State Hearing shall be provided by the CalOptima Health Customer Service Department, by telephone, as requested by the Member.

B. A Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, may request a State Hearing for a review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of service(s) using any of the following methods:

   1. By Mail to:

Attn State Hearings Division
California Department of Social Services
PO Box 944243 MS 9-17-37
Sacramento CA 94244-2430;

2. By calling: 1-800-743-8525 or, for TDD only, 1-800-952-8349;

3. By Fax to: 1-916-309-3487;

4. By Email to: scopeofbenefits@dss.ca.gov; or

5. Online at www.cdss.ca.gov.

C. Continuation of Covered Services (i.e., Aid Paid Pending):

1. CalOptima Health shall grant Aid Paid Pending while the State Hearing is pending if all of the following conditions are met:

   a. The Member filed their Appeal within the required timeframes set forth in 42 CFR 438.420;

   b. The Appeal involves the termination, suspension, or reduction of previously authorized Covered Services;

   c. The Covered Services were ordered by an authorized Provider;

   d. The period covered by the original authorization has not expired; and

   e. The Member files for continuing Covered Services within ten (10) calendar days of when the NOA was sent, or before the intended effective date of the proposed adverse benefit determination.

2. If CalOptima Health, at the Member's request, continues or reinstates Covered Services while a State Hearing is pending, such services shall continue until:

   a. The Member withdraws their request for a State Hearing;

   b. The Member fails to request a State Hearing and continuation of Covered Services within ten (10) calendar days; or

   c. The final State Hearing decision is adverse to the Member.

D. State Hearing Process

1. The DSS Administrative Adjudications Division (AAD) will send a written acknowledgment of the hearing request to the Member, the Member's Authorized Representative (to include completed an authorization for release of protected health information (PHI), Durable Power of Attorney, Legal Guardianship, Conservatorship, and or Executor of Estate), or Provider (with a completed – Member confirmation of Appeal) acting on behalf of the Member and with the Member's written consent, and to CalOptima Health Grievance and Appeals Resolution Services (GARS).

2. The DSS Operations Support Bureau (OSB) shall schedule the hearing, and send written notification that includes the time and location of the hearing to all hearing parties, no later than ten (10) calendar days prior to the hearing.

    a. CalOptima Health shall notify DSS if an interpreter may be necessary at the hearing and the DSS Staff Development Training Bureau (SDTB) is responsible for making arrangements for interpreters to be present at the hearing, if appropriate.

3. CalOptima Health GARS shall be responsible for the administrative coordination of CalOptima Health's responsibilities in the State Hearing process. CalOptima Health shall ensure it provides accurate contact information for CalOptima Health's representative to ensure appearance at the State Hearing via telephone or in-person.

E. State Hearing Postponement, Withdrawal and No-show Process:

1. Hearing parties may request a postponement of a scheduled hearing to a subsequent date not more than thirty (30) calendar days beyond the original hearing date. Postponements may be granted for good cause before the hearing date at the discretion of the DSS State Hearing Support Section (SHSS) or by the hearing judge on the hearing date. Good cause is established if:

    a. The Member has a death in the family, a personal illness or injury, a sudden and unexpected emergency that prevents the Member or Authorized Representative from appearing, or a conflicting court appearance that cannot be postponed; or

    b. CalOptima Health does not make a position statement available to the Member at least two (2) business days prior to the date of the scheduled hearing or modifies the position statement.

2. A Member, or a Provider or Authorized Representative acting on behalf of the Member with the Member's written consent, may also notify DSS of his or her wish to withdraw the hearing request, or to withdraw specific issues identified in the hearing request, at any time prior to a signed decision. If a Member notifies CalOptima Health of his or her intent to withdraw the hearing request, CalOptima Health shall assist the Member by providing the phone number to DSS, connecting the Member to DSS via a conference call, or by mailing the Member a Withdrawal of Request for State Hearing form.

3. If the Member or the Member's Authorized Representative fails to appear at the scheduled State Hearing without good cause, the request shall be considered abandoned. If the Member does not request a reinstatement within ten (10) calendar days from the scheduled hearing date, and present good cause, DSS will notify the Member, in writing, as to the specific reasons for the decision or dismissal, and the right to request a rehearing.

F. CalOptima Health's Pre-Hearing Process

1. A CalOptima Health representative shall research information on the issues presented, contact the Member for clarification of any part of the hearing request that does not clearly set forth the Member's basis for appeal, and make efforts to bring all parties to an agreement on a possible resolution of the matter prior to the hearing.

2. If a CalOptima Health representative concludes CalOptima Health's action was correct, the CalOptima Health representative shall contact the Member to inquire if the Member plans to attend the hearing, determine if there are any further contentions which the Member will

attempt to raise at the hearing and provide information that may be of assistance to the Member as described in Section II.D. of this Policy.

3. CalOptima Health GARS shall determine the issues, review the applicable statutes, regulations, and policies in light of the evidence existing in the case record, and, prior to the hearing, prepare a written position statement, consulting with Legal Affairs as appropriate.

4. Issues at the hearing shall be limited to those reasonably related to the request for hearing, or other issues identified by either the involved agency or the claimant, and jointly agreed upon for discussion prior to or at the State Hearing.

5. Except with regard to an expedited State Hearing, CalOptima Health shall submit a position statement that summarizes the facts of the case, the regulatory justification of CalOptima Health's action, any documentary evidence, and recommendation(s) for resolution. The position statement shall be submitted to DSS via ACMS portal and the Member by certified mail at least two (2) business days prior to the hearing date.

6. A Member or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, may submit a position statement, but are not required to do so, and are not required to make the position statement available to any other hearing party prior to the hearing. If CalOptima Health does not make the position statement available at least two (2) business days prior to the hearing date, or if CalOptima Health modifies the position statement in a way that substantively revises the statement after providing the statement to the Member, the hearing shall be postponed upon the request of the Member conditioned upon the waiver of any decision deadlines.

7. In regard to an expedited State Hearing, within two (2) business days of being notified by DHCS or DSS that a Member has filed a request for a State Hearing that meets the criteria for expedited resolution, CalOptima Health shall submit all information and documents that either support, or that CalOptima Health considered in connection with, the action that is the subject of the expedited State Hearing via ACMS portal. This includes, but is not limited to:

    a. Copies of the relevant prior authorization and Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA).

    b. Any pertinent Notice of Appeal Resolution (NAR) notice. If the NABD/NOA or NAR are not in English, CalOptima Health shall provide fully translated copies to DSS, along with copies of the original NABD and NAR.

    c. All documents CalOptima Health relied on for the denial, including clinical criteria and guidelines.

    d. One (1) or more CalOptima Health or Health Network staff with knowledge of the Member's condition and the reason(s) for the action that is the subject of the expedited State Hearing shall be available by phone during the scheduled State Hearing.

G. State Hearing Phase

1. At the hearing, CalOptima Health will be responsible for the presentation of CalOptima Health's case. The presentation shall include:

    a. Summary of the written position statement;

b. Examining witnesses;

c. Cross-examining the Member and the Member's witnesses;

d. Responding to any questions from the Member or the Member's Authorized Representative, or the ALJ concerning the case; and

e. Having the case record available at the hearing.

f. Merits of a pending State Hearing shall not be discussed between the ALJ and a hearing party outside the presence of the other party.

H. Hearing Decision(s)

1. After a hearing, the ALJ will submit a proposed decision for review by the Chief ALJ or Department of Health Care Services (DHCS) Director, who will adopt a final decision. The final decision will be mailed to the Member and documented via email once uploaded in the ACMS portal to notify CalOptima Health, and will include notice of the right to judicial review or rehearing. Once rendered, the hearing decision shall be considered the final and only notice to the Member on the resolution of the Member's hearing issue.

2. Once notified of the decision, if partially or wholly in favor of the Member, CalOptima Health or a Health Network shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours from the date CalOptima Health received the decision. CalOptima Health or a Health Network must also pay for disputed Covered Services if the Member received the disputed Covered Services while the Appeal or State Hearing was pending.

3. A hearing party may request, in writing, another hearing with the DSS AAD no later than thirty (30) calendar days after the hearing party receives the released decision copy. Upon receipt of the hearing decision, CalOptima Health or the Health Network shall initiate action to comply with the decision, even if a rehearing is requested.

4. If the decision is made wholly or partially in favor of the Member, CalOptima Health shall submit a compliance report to the AAD, using the County Report of Compliance form, when requested by AAD or DSS.

5. If the decision is decided in favor of CalOptima Health, in cases in which Aid Paid Pending was requested, CalOptima Health shall terminate any authorization of the continuance of aid. No additional notification to the Member is required.

6. CalOptima Health's failure to comply with a decision may result in action by DHCS to ensure compliance. In such cases, the Member shall be permitted to request a new State Hearing concerning his or her dissatisfaction with Compliance Issues and Compliance-Related Issues.

7. A Member may contact the DSS verbally, or in writing, if he or she is dissatisfied with the compliance. There is no right to a State Hearing if the request for a hearing is based solely on a Compliance Issue, since the substantive issues have already been resolved, and the remaining issue is one of enforcement only.

8. CalOptima Health shall maintain a database containing information on the number of State Hearing requests filed, scheduled, and resolved, indicating hearing issue, hearing dates, Health Network involved, and Member information.

I. Reporting

1. The written record of all Appeals and Grievances, including State Fair Hearings 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.

2. CalOptima Health 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.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy DD.2005: Member Informing Materials Requirements
C. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
D. CalOptima Health Policy GG.1510: Member Appeal Process
E. CalOptima Health Policy HH.1102: Member Grievance
F. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeals Requirements, Notice and "Your Rights" Templates (Supersedes APL 17-006) (Revised 08/31/2022)
G. Title 22, California Code of Regulations (C.C.R.), §§ 50951 - 50955
H. Title 42, Code of Federal Regulations (C.F.R.), §§ 431.244(f)(1) & (f)(2), 438.10, 438.404(b)(3), & 438.404(c)(3)
I. California Department of Social Services Manual Letter No. CFC-07-01, Regulation 22-073
J. California Welfare and Institutions Code, §§10950 - 10967

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
01/05/2010	Department of Health Care Services (DHCS)	Approved as Submitted
06/10/2015	Department of Health Care Services (DHCS)	Approved as Submitted
06/21/2017	Department of Health Care Services (DHCS)	Approved as Submitted
04/06/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
09/05/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2007	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	01/01/2010	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	10/01/2011	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	01/01/2013	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	01/01/2014	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	04/01/2015	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	06/01/2016	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	07/01/2017	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	03/07/2019	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	06/02/2022	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	12/01/2023	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	09/01/2024	HH.1108	State Hearing Process and Procedures	Medi-Cal

IX. GLOSSARY

Term	Definition
Adverse Benefit Determination	Any of the following actions taken by CalOptima Health: 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. 2. The reduction, suspension, or termination of a previously authorized service. 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. 4. The failure to provide services in a timely manner. 5. The failure to act within the required timeframes for standard Resolution of Grievances and Appeals. 6. For a resident of a rural area with only one MCP, the denial of the Member's request to obtain services outside the network. 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: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b).
Appeal Process	The process by which CalOptima Health and its Health Networks address and provide resolution to all Appeals.
Authorized Representative	A person designated by the Member or a person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Complaint	A complaint is the same as a Grievance. If CalOptima Health is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance.
Compliance Issue	An allegation by the claimant that the county has failed to abide by a state hearing decision concerning issues clearly resolved in the order where the county did not have to make further determinations regarding the claimant's eligibility or amount of benefits.

Term	Definition
Compliance Related Issues	Issues which were not resolved in the prior state hearing decision or resulted from the prior hearing decision requiring the county to make further determinations regarding the claimant's eligibility or amount of benefits.
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. Covered Services do not include: 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; 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; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 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); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 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); 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;

Term	Definition
	8. Prayer or spiritual healing as specified in 22 CCR section 51312; 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); 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); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 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 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; 14. Childhood lead poisoning case management provided by county health departments; 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; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 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.
Deemed Exhaustion	CalOptima Health's failure to adhere to the notice and timing requirements in responding to a Member's Appeal of an Adverse Benefit Determination (ABD), which allows a Member to immediately request a State Hearing.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
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.
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.

Term	Definition
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
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.
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.
Notice Adverse Benefit Determination (NABD)	As a formal letter informing a beneficiary of an Adverse Benefit Determination.
Notice of Action (NOA)	As a formal letter informing a beneficiary of an Adverse Benefit Determination.
Notice of Appeal Resolution (NAR)	A NAR is a formal letter informing a beneficiary that an Adverse Benefit Determination has been overturned or upheld.
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.
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.
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.